MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH after death, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY Pages 1 a. STATE b. COUNTY MARYLAND b. CLTY OR TOWN (if outside Corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENCTH OF STAY IN 1b Wite RURAL and gigo nearest town) hours Baltimore = M. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within NO X completely i YES within 3. NAME OF First Oay DECEASED event, (Type or print) DEATH executed RACELT. MARRIED P remove any eve 6. COLOR OR 8. /DATE OF BIRTH ACE/(IN VESTS/ IF UNDER 1 YEAR NEVER MARRIED IF UNDER 24 HRS ast birthday | Months | and **Davs** Hours 1880 WIDOWER DIVORCED 26 10a, USUAL OCCUPATION (Cive kind of work done | 三 10b. KIND OF BUSINESS OR the attending physician t permit. Then please ation, or removal, and in 11. BIRTHPLACE (County & State, of foreign country) 12. CITIZEN OF WHAT pe during most of working life, even if retired) INDUSTRY COUNTRY? Vone York certificate FATHER'S NAME 14. MOTHER'S MAIDEN NAME Devine Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address death (Yes, no, or unkown) | (If yes give war or dates of service) Jame CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSEL AND DEATH PART I. DEATH WAS CAUSED BY: O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that to Page 4 may be retained by the hospital or attending physician. igned tial-tran IMMEDIATE CAUSE (a) **DUE TO** n si buri Conditions, If any, which (b) gave rise to immediate 라라 **DUE TO** cause (a), stating the has be as th underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(8) certificate h thed for use WAS AUTOPSY PERFORMED? NO T YES 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY Month, Day, Year | 20d. INJURY OCCURREO 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While ATTENDING at work p.m. at work 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should lied with the and that death occurred at 17 VM. from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNAPURE 229. OATE SIGNED ATTENDING M.D. DIRECTOR PHYS. PHYS FUNERAL 22c. PHYSICIAN'S AODRESS 22d. director, p NAME (Type) BURIAL, CREMATION, 23b. OATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 2 REMOVAL (Specify) rematory mation enmount FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SICNATURE OATE 20M 1/65

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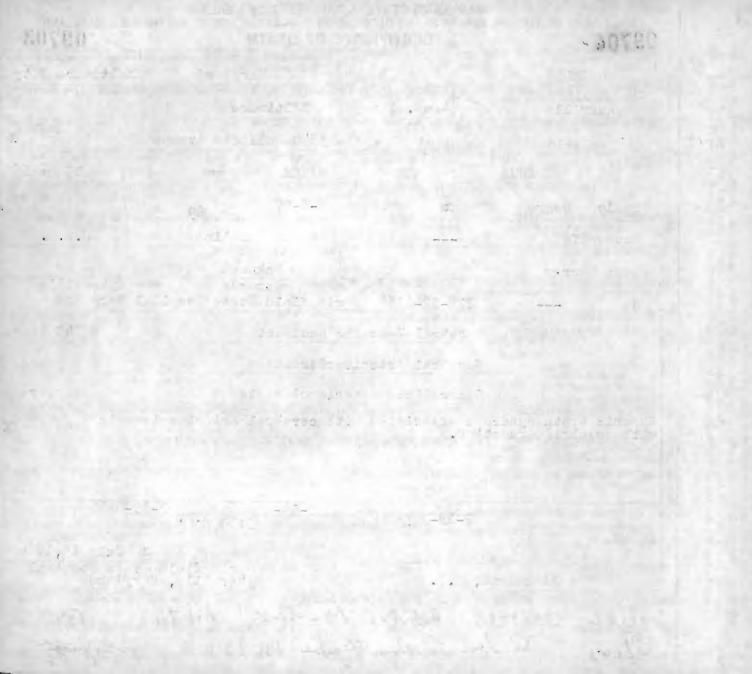
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE a. COUNTY b. COUNTY Carroll Maryland Montgomery MARYLAND non papers. Poges 1 within 72 haurs after physician and completely filled in by the fame of the second papers. Pages h CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Rural--Sykesville 3v. lm. 17d. Chevy Chase IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS NO T 4200 Stanford Street Springfield State Hospital YES T Middle 4. DATE NAME OF First Lost Doy Year DECEASED 19 66 Amanda (NMN) Anderson DEATH and in any event, (Type or print) IF UNDER 24 HRS S SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 st birthday) Months 9 Hours white 10/13/77 female X WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KING OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during mast af working life, even if retired) INDUSTRY Missouri USA 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Rudolph Studhalter Anna Hoehn 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give war ar dates of service) Springfield Hospital records, Sykesville unknown no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **QUE TO** buriol. Canditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying couse oftending the O FUNERAL DIRECTOR: After this certificate has been lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 146). WAS AUTOPS! PERFORMED? for use psychotic reaction. NO YES the hospital or 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED factory, street, affice bldg., etc.) Haur a.m. Not While 19 of wark of wark be retained by 21. I certify that \$\(\omega\$) (this haspital) attended the deceased fram 5/28/, 1963, ta 2/15/, 1966 that (\(\omega\$) (we) last saw the deceased alive an 7/15/, 1966, and that death accurred at 11:00M, from causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING MED. DIRECTOR 7/15/66 M.D. PHYS director, page should be filed 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesville. Maryland Edmee J. Reeves. M. D. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23h. DATE THEREOF (County) (Stote) 23o. BURIAL, CREMATION, Burial -transit 7-16-66 St. Louis, Missouri Sunset Burial Park 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 PUMPHREY, Bethesda, Maryland

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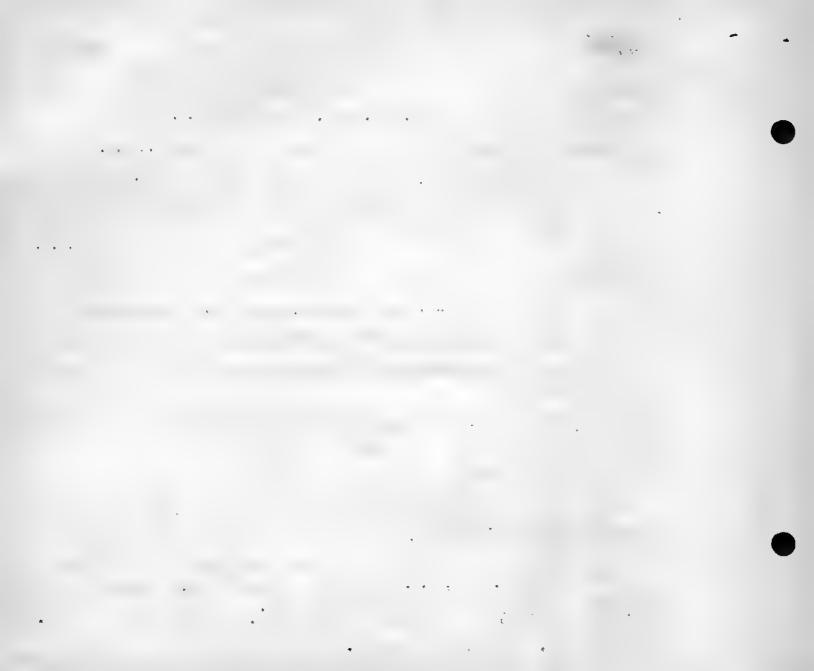
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# 524	09702 CERTIFICATE OF DEATH	09701
er dea	1. PLACE OF DEATH a. COUNTY a. STATE b. COUNTY MARYLAND A. STATE b. COUNTY The county MARYLAND	Residence before admission
by An Pages	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 day. Hanner Pa D 1 # 1	and give nearest town
uted within 24 hours completely filled in by we carbon papers. Pagevent, within 72 hours	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
	3. NAME OF FIRST MIDDLE Last 4. DATE Month	Oay Year
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o it it	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT (A complete) Address (Yes, no or unknown) (If yes give war or dates of service) 210-32.5697 ms. Vontamalonna Han	moter, md
that the deal ician. Ind by the al I-transit perr	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEATH WAS CAUSED BY: Output Death Was Cause	INTERVAL BETWEEN ONSET AND CEATH
ires that physician n signed t burial-tra	Conditions if any which is out to 26 / 1- 1/2 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1	?
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ING PHYSICIAN. d by the hospita After this certif t be detached f State Dept. of f	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Hour a.m. While Not While For Not Wh	unty) (State)
ENDING Prined by 1 R. After ould be could be cou	21. I certify that (I) (this hospital) attended the deceased from Aur 12 , 1966, to July 1 , 196	that (I) (we) las
OR ATTENDING y be retained birector. Af age should like with the S		The date stated above
	ATTENOING MEO. OIRECTOR STAFF OIRECTOR PHYS. 22d. AOBRESS NAME (Type)	dy1,1966
O HOSPITAL Page 4 mai O FUNERAL director, pa	23a. BURIAL, EREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or co	unty) (State)
5° 5 2 2	REMOVAL (Specify) Burial 7/4/66 Manchester Cemetery Manchester 24. FUNERAL DIRECTOR AOORESS 25a. REG'O BY REGISTRAR 25b. REGISTRAR	Md.
VR AIS (4) 20M 1/65	Tipton-Eline Hampstead, Md. DATE JUL 6 1966 gcla	rle Judge

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09706 PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. the ottending physician and completely filled in by the faneral sit permit. Then please remove carbon papers. Pagest i and 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission PLACE OF DEATH Prince George's a. COUNTY Maryland Carroll MARYLAND c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) event, within 72 haurs aft b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 19yrs.5mos.15dys. Washington, D.C. Sykesville d. NAME OF HOSP, TAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RES DENCE ON A FARM? remove carbon popers n any event, within 72 h 6706 White House Rd. S.E. Springfield State Hospital NO E YES Middle 4 DATE 3. NAME OF Last Month Dov Year DECEASED BEALL RUSSELL EASTMAN JULY 19 66 DEATH (Type or print) IF UNDER 24 HRS IF UNDER 1 YEAR 8. DATE OF BIRTH 9. AGE (In years S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED Months birthdoy) Doys Hours 10-13-1892 White DIVORCED Male WIDOWED 100 USLAL OCCUPATION (G ve kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) Ξ COUNTRY? during most of working life, even if retired) INDUSTRY Maryland U.S.A Odd jobs 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME Sprigg Beall Sarah Sansbury 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, na, ar unknown) (If yes give war or dates af service) signed by the ottendir burial-transit permit. 220-54-7585 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE (AUSE (o) Mesenteric artery thrombosis Page 4 moy be retained by the hospital or attending physician. DUE TO (b) Coronary artery disease of heart Conditions, if any, which gave Years rise to immediate cause (a). DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been be detoched for use os the Stote Dept. af Heolth prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CBS assoc. with convulsive disorder, with psychotic reaction WAS AUTOPSY PERFORMED? YES IK NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 18.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While at work __, 19___, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from 1-16-17 ___, and that death occurred at 6:15" saw the deceased alive on 7-1-66 Marrom causes and on the date stated above. 19. 226. DATE SIGNED 22a SIGNATURE MED. DIRECTOR STAFF PHYS. 7-1-66 X M.D. director, page 3 should be filed v 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN S Octavio A. Ruiz. M.D. NAME (Type) Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY Cem. 23d. LOCATION (City or Town) 230 BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) BUREMOVAL (Specify) 7/3/66 Md. Forest Memorial Meth. Forestville 2Sb. REGISTRAR'S SIGNATURE 25g. REC D BY REGISTRAR 24 FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro. Md. Meanley Judge 1956 DATE



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09707 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH pllysican and campletely filled in by the funeral en please remave carbon papers. Pages 1 and oval, and in any event, within 72 haurs after dedfavol, and in any event, within 72 haurs after dedfavol. o. COUNTY Maryland Baltimore Carroll MARYLAND b CITY OR TOWN (If outside carparate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) r LENGTH OF STAY IN 1b write RURAL and give nearest tawn) Rural - Boring Westminster e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d. STREET ADDRESS Carroll County General Hospital YES TO NO 3 NAME OF Middle Last 4. DATE Month Day Year DECEASED (Type or print) OF 1966 BELT OSBORN HATTIE DEATH IF JNDER 1 YEAR IF UNDER 24 HRS. S. SEX 8 DATE OF BIRTH 9. AGE (In years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED Months OLLyrs. last Haurs 2/10/82 $\overline{\mathbf{x}}$ WIDOWED DIVORCED White Female 10g USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUSEA Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Elizabeth Akehurst John D. Osborn signed by the attending p burial-transit per the Angle a burial, crematian or reman 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Address 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war ar dates of service) 212-38-2216 Mr. L. Russell Osborn, Boring, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) DISET AND DEATH PART I. DEATH WAS CAUSED BY: OBSTRUCTION LNITESTINAL IMMEDIATE CAUSE (a) DUE TO YMOS. BOWEL CARCINOMA OF Conditions, if only, which gove rise to immediate cause (o), DUE TO stating the underlying couse Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been detached far use as the te Dept. af Health priar ta last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? CERTIF CATION NO M 205, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED Nat While factory, street, affice bldg., etc.) 1966_10 . 1966 . that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 1966 and that death accurred at 1123 M. fram causes and an the date stated above saw the deceased alive on 220. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR M.D. 22d. ADDRESS PHYSICIAN'S NAME (Type) directar, shauld b 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 230. BURIAL, CREMATION, REMOVAL (Specify)
Burial 7/11/66 Pleasant Grove Balto. Co. Md. 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Charles VR A15 (4) Tipton-Eline Hampstead. Md. 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09708 CERTIFICATE OF DEATH death The law requires that the death certificate be executed within 24 haurs after death. and ician and campletely filled in by the funeral lease remove carbon papers. Pages I and 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY o. COUNTY Carroll MARY! AND b CITY OR TOWN (If outside corporate limits, write RURAL opd give nearest town) c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) within 72 haurs 7 mos./1 da. Middleburg. Sykesvi 21758 d. STREET ADDRESS B. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springeriald State Mosnital YES NO [3 NAME OF Middle 4 DATE Month First Lost Doy Year DECEASED (Type or print) DOCKSTTTER Robert Gibson July 19 DEATH IF LINDER 24 HRS S. SEX 6. COLOR OR RACE 7 MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR NEVER MARRIED last pirthdoy) Doys Hours 11-33-23 - 1 te DIVORCED rale 12. CITIZEN OF WHAT 100 JSUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote or foreign country) COUNTRY? INDUSTRY during most of working life, even if retired) Played in Churches Maryland 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Robert B ckriller - dec. Clara IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dates of service) Orbin field State Homital Ruc rds INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY Brain abscess cause undetermined IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO far us as the t stating the underlying couse Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? Inanition. Multiple decubitis. YES T NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACC DENT WAS UNDERLYING [1] detachind f te Dept. af l OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) at wark 21. I certify that (I) (this haspital) attended the deceased from 12-27-05, 19 and that death accurred at 6 _____, ta_____/-30-66__, 19____, that (I) (we) last and that death accurred at 2 p.M. fram causes and an the date stated above saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED DIRECTOR Spring. 22d. ADDRESS 9+210 22c. PHYSICIAN'S NAME (Type) 112 m. 230 BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Loudon Park Cemetery Baltimore, Md.

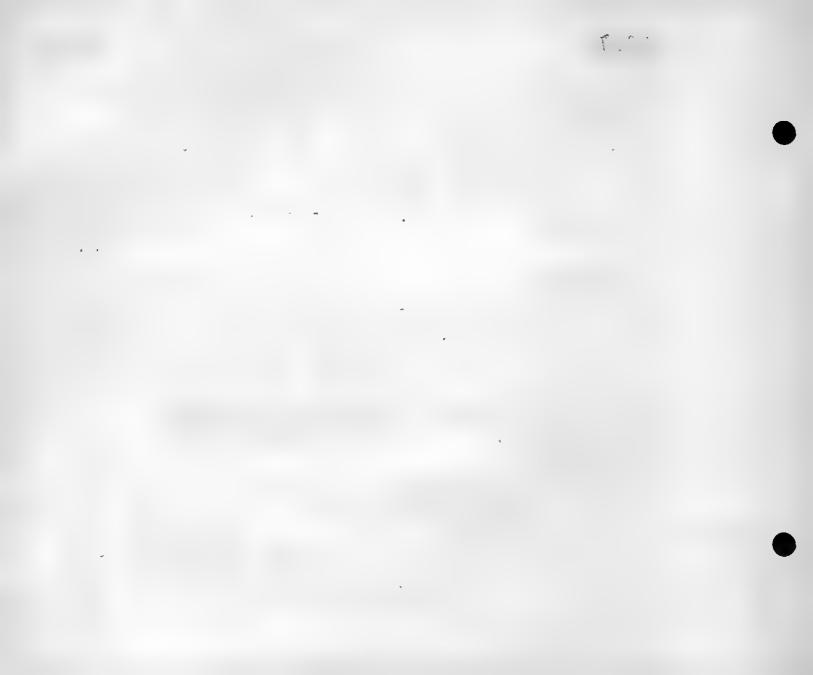
TRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR Melanley Judge VR A15 [4] aston Euneral Nome Catonsville, Md. 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09709 CERTIFICATE OF DEATH death. by the funeral Pages 1 and 2 The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) I. PLACE OF DEATH o. (Oulviv Carroll o STATE Maryland b COUNTY signed by the attending-physician and campletely filled in by the fun burial-transit permit. Then, please remave carban papers. Pages 1 burial, cremation, ar rechavit, and in any event, within 72 haurs after i BaltimoreCity MARY! AND c. CITY OR TOWN (If autside carparate limits, write RURAL and give neorest town) b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 write RURAL and give necrest town) 1;r.11m0 7 d Sykesville Baltimore e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS NO S Springfield State Hospital 2002 Girard Avenue YES I 3 NAME OF Middle 4. DATE Manth Year Day DECEASED BOWERSOX (Type or print) CHARLES. HENRY DEATH IF UNDER TYEAR 9. AGE (In years IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH lost birthday) Months Whi te Male 12 CITIZEN OF WHAT COUNTRY? 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)

Plumber INDUSTRY II.S.A Maryland 14. MOTHER S MAIDEN NAME 13 FATHER'S NAME Elizabeth Shaffer Charles Bowersox 16. SOCIAL SECURITY NO. 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) 214-18-5841 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY ONSET AND DEATH Uremia IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Nephrosclerosis Years Conditions, if any, which gave rise to immediate cause (o). DUE TO far use as the b Health prior to b stating the underlying couse ro FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction. 19 WAS AUTOPSY PERFORMED? YES NO 20g. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Haur am. Nat While ot wark at work 21. I certify that (I) (this haspital) attended the deceased from 8-11-64 , 19 ta Jidy 10, 19 65that (1) (we) last and that death accurred at 6.15AM, from causes and an the date stated above. saw the deceased alive an_ 22b. DATE SIGNED 22a, SIGNATURE ATTENDING PHYS STAFF PHYS. M.D. DIRECTOR director, page 3 should be filed v 22d ADDRESS Springfield State Hospital 22c. PHYSICIAN'S "..'uar 'J R. Acle M.D. NAME (Type) Sykesville Maryland 2178L 230 NAME OF CEMETERY OR CREMATOR 23d-LOCATION (City or Town) (County) (Stote) 23g BURIAL CREMATION. 236 DATE THEREOF RSMOVAL (Specify) vanne 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



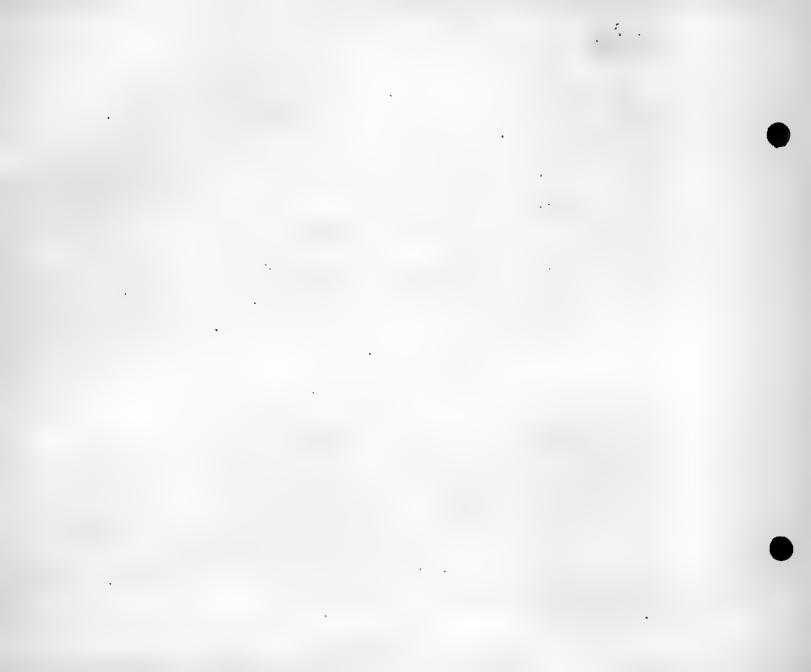
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09709 09710 the attending physician and campletely filled in by the funeral sit parmit. Then please remove carban papers. Poges 1 and 2 requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH **b** COUNTY o. COUNTY Carroll MARYLAND b CITY OR TOWN (If outside corporate imits, write RURAL and give nearest town)
Sykesville c CITY OR TOWN (If outside corporate limits, write RURA), and give nearest town) C LENGTH OF STAY IN 16 6 mos./5 das. Silver Spring 20910 d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 35.12 Fairview Frad Springfield State Hosp'tal YES NO DO 4. DATE 3 NAME OF Middle Month (Type or print) BRANdt DEATH IF UNDER 24 HRS 9. AGE (In years) S. SEX 7 JOHANNOED CRESCONTIVER MONDULEUX ST 8. DATE OF BIRTH last birthday) Months Hours 2-13-1397 whi e WIDOWED fr ale 12. CITIZEN OF WHAT 10a USLAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) COUNTRY? Own Home Lar land 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Elizabeth John Kratz - dok 17 INFORMANT Valter W. Brandt IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. burial-transit permit. Burial, cremation, or re 1415 Stateside Dr. (Yes, no, or unknown) {(If yes give war or dates of service) None 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Bronchopne . ia. IMMEDIATE CAUSE (a) DUE TO b) waterns Mollitus. Canditians, if any, which gove nse to immediate couse (a), DUE TO far use as the f stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO ILUNIRAL INKICIER: After this certificate has billing. WAS AUTOPS PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? Chronic Irain lyndrene as re. with core ral art misscloredis. NO fe 200 ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Not While factory, street, office bldg., etc.) White at work at work 21. I certify that (1) (this haspital) attended the deceased fram 12/28, 1965, ta 7/3, 1966, that (1) (we) last saw the deceased glive an 3 4 5 1966, and that death accurred at 8.755 M, fram causes and an the date stated above , 1965, to 7/3 ____, 19 66, that (I) (we) last 22b. DATE SIGNED 220 SIGNATURE Wiri STAFF PHYS. July 3, 1966 M.D. 22d. ADDRESS Springfield State Hospital 22c PHYSICIAN'S NAME (Type) Samuel P. Wise, ITV. H.D. Sykesville, larmland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION 236 DATE THEREOF REMOVAL (Specify) Parklawn Cemetery Rockville, Maryland 25b. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR Melanley 1966 DATE



1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
e week		0971; CERTIFICATE OF DEATH	09210		
death, uneral and ceath,	1.	PLACE OF DUIL 2. USUAL RESIDENCE (Where deceased lived, if institution:	Residence before admission		
24 hours after death. filled in by the funeral napers. Pages 71 and 172 hours after death.		a. COUNTY CARROLL B. COUNTY C. MARYLAND B. COUNTY C.	Arcall		
s aft by th Pages irs aff	1	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	AL and give nearest town		
hours in by S. Pags.	Ko	THE SURESVILLE TO THIS I NOTH SURESVILLE	' 1		
24 hours filled in papers. Filin 72 hou		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	8. IS RESIDENCE ON A FARM?		
ly fa	3.	BATTHIOW KOAD BATTHIOW Rd.	YES NO 🔀		
executed within 24 h and completely filled remove carbon papers n any event, within 72	3.	NAME OF DECEASED (Type or print) William McKinley Brooks 4. DATE Month OF DEATH July	23. 1966		
com com ve c	5.		ER 1 YEAR IF UNDER 24 HRS		
e be execute sician and co lease remove and in any ev		MINITE WIDOWED DIVORCED 7" 10- 1878 67 VICE			
	du	the mest of working life, even if retired) INDUSTRY 1//)	CITIZEN OF WHAT		
₽ <u>>a</u> -	13	FATHER'S NAME 14. MOTHER'S MAIDEN NAME	U. SIA .		
certificate be nding physiciar Then please removal, and i	-	Benismin Rooks Alice Hill			
	15	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	.1 444		
desth certifica e attending ph permit. Then ion, or removal	(1:	10 No (If yes give war or dates of service) 219-05-0370 Mrs. MARY Green - Syk	esville, Ald.		
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
at the		PART I. DEATH WAS CAUSED BY: Cirrhosis of liver, severe	Ottos Aus servi		
law requires that the destated attending physician that been signed by the attention as the burial-transit permit prior to burial, cremation,		DUE TO	Jan. 1966		
uire g ph en s bus o bus		Conditions, if any, which gave rise to immediate (b) Malnutrition	through		
		cause (a), stating the DUE TO underlying cause last. (c) Anemia: cardiac failure with errest.	7/23/66		
law atter has has e as e as	NO.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?		
The cate r us earth	1CAT		YES NO		
ATTENDING PHYSICIAN: The law requires that the described by the hospital or attending physician FECTOR: After this certificate has been signed by the 3 should be detached for use as the burial-transit pewith the State Dept. of Health prior to burial, cremation	CERTIFICATION	ZOB. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	(8.)		
HYS. the her this etac Dep	SE		county) (State)		
DING P ed by t After d be d e State	MEDICAL	Hour a.m. While Not While p.m. 19 at work at work			
ATTENDING retained by CTOR: After 3 should be with the Stat		21. I certify that (I) (this hospital) attended the deceased from Jan., 19.66, to July 23, 19.	66, that (I) (we) las		
CTO Sto		saw the deceased alive on July 23, 19.66, and that death occurred at 7:30 M, from the causes and on 22a. SIGNATURE	the date stated above		
od w	1	ATTENDING MED STAFF			
TAL MAL Dag		22c. PHYSICIÁN'S	y 27, 1966		
HOSPITAL age 4 may FUNERAL rector, pa		NAME (Type) Howard E. Hall, M.D. Sykesville, Maryland			
TO HOSPITAL OR ATTENI Page 4 may be retaine for EUNERAL DIRECTOR: director, page 3 should should be filed with the	23	REMOVAL (Specify)	county) (State)		
	3	SUFIAL 1-27-66 OT, LOKE (EMERLY DUKESVII)	AR'S SIGNATURE		
VR ALS (4)		LAME YU. Haight Sykesville Md. DATE JUL 29 1966 July	wells Judge		
20M 1/65					



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLANI)
# #O#	09712 CERTIFICATE OF DEATH 0971	1
death.	1. PLACE OF DEATH a. COUNTY a. STATE b. COUNTY	admission)
after of arter	MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND	
by the	b. CITY OR TOWN (if outside corporate limits, write RURAL end give near write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town)	rest town)
nours .	Mostrumette 12 m. Motommeter PD#6	FAIRENDE
filled filled in 12 %	ON.	A FARM?
il Significant	3. NAME OF STATE MIDDLE Lest 4. DATE Month, Day	Year
ING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death to by the hospital or attending physician. We have a corrificate has been signed by the attending physician and completely filled in by the funeral be detached for use as the burial-transit permy. Then please remove carbon papers. Pages 1 and 2 State Dept. of Health prior to burial, cremation, became, and in any event, within 12 hours after death the control of the con	(Type or print) BABY GIRL BUCHANAN OF JULY 6 1	966
utec	5. EX 6. GOLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in years IFUNDER 1 YEAR IFUNDER	
and and rem	Timble WIDOWED DIVORCED VILT 4 1966 O VIS O - Z	110
be cian ase nd in	11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF THE GOUNTRY? 12. CITIZEN OF THE GOUNTRY?	IAI
ate ple al, a	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
Till Till	Wardrow Buchanger Sudith Carr	
es igia	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. LINFORMANT Address (Yes, no, or unknown) ((If yes pive war or dates of Service)	D#6
s att	- Woodron Buclaman Witnesser	ml
requires that the death certificate be ding physician. been signed by the attending physician the burial-transit permise then please or to burial, cremation becomes and in	18. CAUSE OF GEATH (Enter only one cause per line for (a), (b), and (c),) ONSET AN ONSET AN	BETWEEN D DEATH
at t	PART I. DEATH WAS CAUSED BY: Multiple Congenitive & Univaltage UNSET AN	
sign Sign Sign Sign Sign Sign Sign Sign S	Conditions, If any, which \ Conditions of the Co	
quir ng p p to bu	gave rise to immediate cause (a), stating the DUE TO 3 double left by and predate	
law re ttendii has be as th prior	underlying cause last. (c) Prepulturity 2'10"	
The far or att or atte ate ha	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS PERF	AUTOPSY ORMED?
i: Th al or ficat for u	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURATED. (Enter hature of injury to Pert II of Item 18.)	No 🗌
PHYSICIAN: The law requires that the hospital or attending physician. this certificate has been signed by detached for use as the burial-transe Dept. of Health prior to burial, cre	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS PERF YES 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
the this fetac	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) 4 work 20f. (City or town) 2	(State)
DING P od by t After d be d d be d e State	Hour a.m. While Not While at work at work at work	
OR ATTENDING by IRECTOR: After 3 should be edd with the State	21. I certify that M (this hospital) attended the deceased from 7 6, 1966, to 7 6, 1966, that (If	
E SPORTE	saw the deceased alive on 19, and that death occurred at M, from the causes and on the date state 22a. SIGNATURE	ed above.
DIRE Be 3 ed w	M.D. ATTENDING MED. STAFF 7/4/66	
TO HOSPITAL OR ATTENDIN Page 4 may be retained to FUNERAL DIRECTOR: Afficiency, page 3 should be filed with the SI	22C. PHYSICIAN'S NAME (Type) KARL W. GRFEN M.D. 22d. ADDRESS NAME (Type) KARL W. GRFEN M.D. 22d. ADDRESS M.D.	
HOSI Sge 4 FUNE ould	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEME) ERY OR CREMATORY 23d. LOCATION (City, town or county)	(State)
5 5 5 6 8 V	Bremoval (Society) 7/4/66 Deer Parts Cemiting Rund Westminter	mel
K	24. FUNERAL DIRECTOR ADDRESS JSa. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURA	4.
VR AI5 (4) 20M 1/65	2. myers B. Westmington, monte JUL 8 1966 Jolianles Jun	7
Zum 1/03		7



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH I. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed fixed, If institution, Residence before admission) a. COUNTY b. COUNTY Harford Carroll Maryland MARYLAND b. CITY OR TOWN (if putside corporate limits, & LENGTH OF STAY IN 16 c. CITY OR TOWN (if outs de corporete imits, write RURAL end quye nearest town) write RURAL end give nearest town) days Bel Air Henryton d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp to , g ve street address) d STREET ADDRESS . IS RESIDENCE ON A FARM? Conowingo Road, Box 841 YES NO K Henryton State Hospital 3. NAME OF Middle DECEASED OF (Type or print) DEATH 19 66 Caudill July Milåreå Frona with: 5. SEX 6. COLOR OR RACE 7. MARRIED THEYER MARRIED 19. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) | Months Female WIDOWED [D. VORCED 10-20-24 10a. JSLAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHP, ACE (County & State, or for ign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) None Harford Co., Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Stella Hamm Bert M. Caudill 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 116 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unkown) | (If yes give we rordates of service Mrs. Stella Caudill - Same as patient Nο 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Cardiovascular insufficiency IMMEDIATE CAUSE (a) DUE TO undetermined cause Conditions, if eny, which gave rise to immediate cause DUE TO (e), stating the underlying PART II, OTHER SIGNIF, CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO X 20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH UF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL (County) 20c. TIME OF INJURY Month, Dey, Year 1 20d, INJURY OCCURRED 1 20s. PLACE OF INJURY (Home, farm, 1 20f. (City or town) (State) fectory, street, office bldg., etc.) While Not While et work at work 21. I certify that (I) (this hospital) attended the deceased from August 10 1964 to July 1966, and that death occurred a 9:19, from the causes and on the date stated above. saw the deceased alive on July 25 22e. SIGNATURE ATTENDING DIRECTOR TO PHY5. PHYS. 22d, ADDRESS 22c. PHYSICIAN'S NAME (Type) Henryton, Maryland Edgars M. Maculans, M. D. 23e. BUR AL, CREMATION, 1 23b DATE THEREOF 1 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) WElcome Home Brotist Church Gen Bel Air Harford Co. -July 27, 1966 0 25a, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 9/60 W. Beandway

ARYLAND STATE DEPARTMENT OF HEALTH



_	09714	CERTIFICATE		JIRLEI, DALI	IMORE 1, MARYLA
1.	PLACE OF DEATH				sved, If institution: Residence
	Carroll	MARYLAND	a. STATE		Carroll
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest lown)	c LENGTH OF STAY IN 16			nits, write RURAL and give ne
	Rural Detour	Lifetime	Rural	Detour	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in ho		d. STREET ADDRESS	200000	
3.	NAME OF First DECEASED	Middle	Last	4. DATE OF	Month Day
	(Type or print) Reuben	Edward	Clabaugh		uly 22
5	SEX 6. COLOR OR RACE 7. MARRI	ED NEVER MARRIED 3	DATE OF BIRTH	9. AGE (In years IF UNDER I YEAR
	Male White WIDOW		an. 14, 1900	1857 bi	rthday) Months Days
10	a. USUAL OCCUPATION (Give kind of work 10b.	KIND OF BUSINESS OR INDUSTR			·
d	reducing most of working life, even if retired) Farmer		Carroll	CO. Marvla	nd U.S.A.
13	FATHER'S NAME		14. MOTHER'S MAIDEN		, , , , , , , , , , , , ,
	John Edward Clabaugh		Carrie W	ilhide	
	WAS DECEASED EYER IN U.S. ARMED FORCES? 16	. SOCIAL SECURITY NO. 17.			Address
	ns, no, or unkown) (If yes give war or dates of service)			shaugh De	tour, Marylan
-	NO	<u> </u>	Ollar Ten OT	abaugna be	INTE
	PART I. DEATH WAS CAUSED BY:	Timoschum	Tax Idean	= 12 mar	ONS
	IMMEDIATE CAUSE (a)	Con Contraction of Contraction	775		-
	Conditions, if any, which) (b)	menaling	A 1) 15	James Porce	Ara I
	gave risa to immadiata causa	7	4 Composition	A STATE TO STATE OF THE STATE O	
	(a), stating the underlying DUE TO				
7	PART II. OTHER SIGNIFICANT CONDITIONS CO	NTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMIN	NAL DISEASE CONDIT	ION GIVEN IN PART I(a) 19
0	1/1/1/07	7/- 2/			Y
FICA	20a. ACCIDENT WAS UNDERLYING [] 20b. D.	ESCRIBE HOW INJURY OCCURR	ED LEGICA SATURE OF INTURY II	Part I or Part II of ite	
CERTIFICATION	OR CONTRIBUTING CAUSE OF DEATH	ESCRIBE HOW BYOM OCCORN	and the same of Mary II		
		, INJURY OCCURRED 20e, PLA	ACE OF INJURY (Home, farm	. 1 20f. (City or town	n} (County)
MEDICAL	Hour a.m. Whi	leNot Whila fac	tory, street, office bldg., etc.)	(20211)
ME	p.m. 19 at wo		110	1/5	1-2:11
	21. I certify that (I) (this hospital) atter			1962 to?	
	saw the deceased alive on	196 Ca and that	death occurred at	M, from the o	causes and on the date
	228. SIGNATURE	a A	ATTENDING	NED STA	
	K 121111	Market S N	3.0.	PHY	5. // ==
	22c. PHYSICIAN'S NAME (Type)	c Vy wal	22d. ADDRESS	2221	sub M
		- Two-yn	JC1.V	1844	1/1/2
_	B. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d, LOCATION	(City, town or county)
23	REMOVAL (Specify)				
	Burial July 24,1966		emetery	Keysville	, Carroll Co.
	REMOVAL (Specify)	Keysville Ce	emetery 25a, REC	Keysville Keys	25b. REGISTRAR'S SIGNATURE OCCUPAÇÃO DE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09715 d completely filled in by the funeral CERTIFICATE OF DEATH 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased fived, if institution Residence before admission). o. COUNTY **b** COUNTY Carroll MARYLAND c CITY OR TOWN (If buside carparate limits, write RURAL and give neares flown) b, CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 Silver Spring 13d 20910 11m Rural) Sykesville e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS YES T NO 🚾 1229 Noves Drive Springfield State Hospital The law requires that the death certificate be executed within DATE 3. NAME OF First Middle Lost Manth Day Year DECEASED OF Guy (Type or print) Ralph Cornell DEATH 19 66 YEAR IF JNDER 24 HRS. 9 AGE (In years S SEX B DATE OF BIRTH **6 COLOR OR RACE** 7. MARRIED NEVER MARRIED birthday) Hours Manths 5-20-91 DIVORCED WIDOWED remy male white ottending physicion and sermit. Then please rem or removal, and in or 12. CITIZEN OF WHAT 10a JSUAL OCCUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) COUNTRY? USA during most of working life, even if retired) INDUSTRY GUt. New York Lawuer --13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME uniknosa Agusta Engalls Joseph Cornell WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO rene A. Cornell Add/229 Noves Drive (Yes, na, ar unknown) (I yes give war or dates of service)
Army 1946 220-34-8453 Aleguided Menoris cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) signed by the buriol-transit p buriol, crematic PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Congestive Heart Failure IMMEDIATE CAUSE (o) Poge 4 may be retained by the hospitol or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by rteriosclerotic vascular disease Conditions, if any, which gove years rise to immediate couse (a), DUE TO stating the underlying couse os the prior to east ii. Other significant conditions contributing to death but not related to the Terminal disease condition given in part 1(a) chronic brain disease with 19. WAS ALTOPSY PERFORMED? use NO 🔀 YES Pneumonia. for 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of migry in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED foctory, street_office bldg., etc.) Hour a.m. Not While at work at wark þe 19 66 that (M (we) lost 21. I certify that (1) (this hospital) attended the deceased from 8-6 19 65 to 7-19 P 19 66, and that death accurred at 10:14, from causes and on the dote stoted above. saw the deceased alive on 7-19 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. ATTENDING 7-20-66 DIRECTOR director, page should be filed 22d. ADDRESS 22c PHYSICIAN'S Springfield State Hospital Heinz H. Klaatsch. M.D. NAME (Type) 23c NAME OF CEMETERY OR CREMATO PICE SVII 23b DATE THEREOI (County) (State) 23a. BURIAL CREMATION. BULLAL (Specify) Prince Georges It. Lincoln Cemetery (0. oknisthern 84 34 Georgia Ave. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Ocharles VR A15 (4) DATE JU 20 M 1/66



RYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH USUAL RESIDENCE (Where decreased lived. If institution, Residence before admission) a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits c. LENGTH OF STAY IN 16 d. STREET IS RESIDENCE ON A FARM YES NO TO NAME OF DECEASED 19 60 6 and cor COLOR OR RACE 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. birthday) WIDOWED IT 12. CITIZEN OF WHAT COUNTRY 15. WAS DECEASED EYER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO 17. INFORMAN (Yes, no, or unkown) [(Ifyesgivewerordetesofservice) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: SCLEROTIC IMMEDIATE CAUSE (e) DUE TO DISEACE Conditions, if eny, which (b) gove rise lo immediate causa **DUE TO** (a), stating the underlying cause lest. PART HE OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART HOL. 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 200, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of neury in Part I or Part if of item 18.) OR CONTRIBUTING [CAUSE OF DEATH UF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Dev. Year 20d. INJURY OCCURRED. 2De. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While Hour a.m. at work at work 21. I certify that (I) (this hospital) attended the deceased from .. and that death occurred at M. from the causes and on the date stated above. saw the deceased alive on 22b. DATE ATTENDING SIGNED, PHYS. 22d. ADDRESS 22c. PHYSICIAN'S (Slete) 23a. BURIAL. CREMATION. REMOVAL (Sbecify) REC'D BY REGISTRAK PUNERAL DIRECTOR'S SIGNATURE VR A15 (4



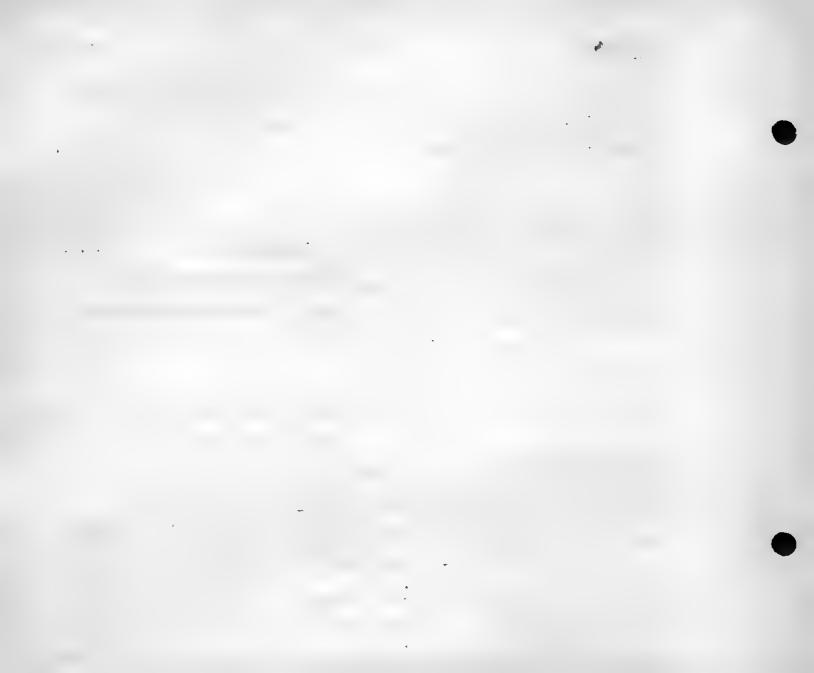
1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	09717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09716
HEALTH DEPT	1. PLACE OF DEATH a. COUNTY MARYLAND A. STATE Maryland Carroll A. COUNTY Maryland A. County Maryland Maryland Maryland Maryland Maryland Maryland Maryland Maryland
o the funeral o the funeral e 5 may be 5 may be 1 Department after death.	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Westminster C. LENGTH OF STAY IN 1b Westminster
S r S r	G. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREFT ADDRESS e. IS RESIDENCE
nd 3 to to Page Page State D	27 E. Main St. 27 E. Main St. YES NO K
y de M3. M3. T2 h	3. NAME OF DECEASED (Type or print) HERMAN Widdle CUII/SON 4. DATE Month 2 19 66
	5. SEX 6. CDLOR DR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE (In years FUNDER 1 YEAR IF UNDER 1
ages for 2 v	Male White WIDDWED DIVORCED X // 4//2 53 yrs.
ter death. If ar Give Pages 1, 2 g with form P 1 and 2 with	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
afte Gire	Road work Maryland USA 13. FATHER'S NAME 14. MDYHER'S MAIDEN NAME
alcon alcon	
1 ten 1 ten 1 ten 1 tile 2 and	L. Kurtz Cullison Estie Wilhelm 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
within 2 pencil in miner's 0 permit. I	(Yes, roo, or unknown) (Il yes give war or dates of service) 703 - 10 - 7/73 Mr. Atlee Cullison Hampstead, Md.
with senciner iner	1 18. CAUSE OF DEATH (Enter only one couse per time for (a), (b), end (c).)
Exame Exame or r	PART I. DEATH WAS CAUSED BY: CAR CHECK IN JUNE ONSET AND DEATH IMMEDIATE CAUSE (a)
uld be executed d "pending" in ef Medical Exan a burial-transit) cremation, or u	4-201 DUE TO
be endedictions of the second	Conditions, if any, which (b) (b)
a bu	cause (a), stating the DUE TO
sho Wor Chi	
ficate shot the word o the Chie used as a	PERFORMED? YES NO NO
R, This certificate, writing forwarded to 3 should be agent, prior 1	2Da. EXTERNAL CAUSE WAS 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) PRIMARY or CONTRIBUTING CAUSE OF DEATH.
EXAMINER: This certificate should be executed within e certificate, writing the word "pending" in pencil inshould be forwarded to the Chief Medical Examiner's files. OR: Page 3 should be used as a burial-transit permit.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY OF CONTRIBUTING COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY OF CONTRIBUTING COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY OF CONTRIBUTING COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) PRIMARY OF TOWN OF THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY YES COUNTY IN PART 1 OF PART II OF ITEM 18.) PRIMARY OF CONTRIBUTING COURSED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) 19. WAS AUTOPSY YES COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY OF TOWN OF THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY YES COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY OF TOWN OF THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY YES COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY OF TOWN OF THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) 19. WAS AUTOPSY YES COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.) PRIMARY OF TOWN OF THE TOWN OF THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) 19. WAS AUTOPSY YES COURSED. (Enter nature of Injury In Part 1 or Part II of Item 18.)
the certifice the should be in files. CTOR: Page designated a	21. I certify that I took charge of the remains described above, held an Autopsy
EXA he co shoul files. for:	death resulted from: Natural causes . Accident ., Suicide ., Homicide ., Undetermined manner .
EDICAL ute the ge 4 s your 4 your 11s de its de	ACTUAL TOTALIST C. () COSTO FULL ACCIDENT MEDICAL EXAMINER []
TY MEDIA execute Page I for you RAL DIRE	SIGNATURE COULT FULL M.D. ASSISTANT MEDICAL EXAMINER 772-66
or. ex	EXAMINER'S NAME (Type) Address (Street, city, town, or county) ARROLL
O DEPUTY MEDIC. EXA please execute the codirector. Page 4 shour retained for your files. O FUNERAL DIRECTOR: of Health or its design	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
To de	REMOVAL (Specify) Burial 7/5/66 Grace Cemetery Balto.Co. Md. 24. FUNERAL DIRECTOR ADDRESS 252. REGISTRAR'S SIGNATURE
AISME (5)	
5M 1/65	Tipton-Eline Hampstead, Md. DATE JUL 1966 for fully



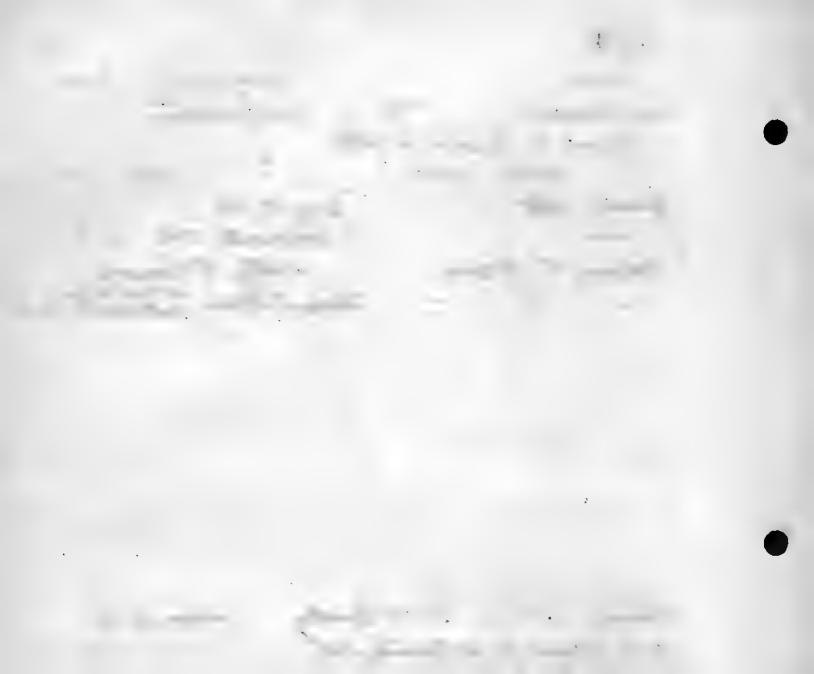
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death requires that the death certificate be executed within 24 haurs after death physician and campletely filled in by the funeral en blease remave carbon papers. Pages Land 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND Maryland Montgomery

c CITY OR TOWN (if autside corparate limits, write RURAL and give necessity own) b. CITY OR TOWN (If autside corparate fimits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 no days Sykesville Gaithersburg d NAME OF HOSPITA. OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STREFT ADDRESS within 72 Springfield State Hospital Route #3 3 NAME OF Middle Last 4 DATE Month DECEASED July 15 GLADYS OPAL DALTON 19 (Type or print) DEATH S SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH 59 yrs. Months Days 12-25-06 White DIVORCED Female WIDOWED 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) COUNTRY? INDUSTRY None Virginia

14. MOTHER'S MAIDEN NAME II.S.A 13. FATHER S NAME Marion (Maiden name unknown) Hosea Dalton IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) ((If yes give war or dates of service) No Unknown Records, Springfield State Hosmital crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit p ONSET AND DEATH PART I DEATH WAS CAUSED BY. Possible Hodgkins Disease THETHER IMMEDIATE CAUSE (a). DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse Page 4 may be retained by the haspital ar attending as the O FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS' PERFORMED? far use Health r . Late d'obrier and prychotic reaction. NO 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year factory, street, affice bldg., etc.) Haur a.m. Nat While at wark 21. I certify that (I) (this hospital) attended the deceased from ______, - 00 , 19____, that (I) (we) lost M. from tauses and on the date stated above. director, page 3 should should be filed with the ____, and that death occurred at___ 22b. DATE SIGNED 22a. SIGNATURE ATTENDING 7-15-56 DIRECTOR 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesville Maryland 21984 23c. NAME OF CEMETERY, OR CREMATORY 23d. LOCATION (City or Town) 23o BURIAL CREMATION. 23b DATE THEREOF (County) (Stote) REMOVAL (Specify) Sunset Wordstock 25b. REGISTRAR S SIGNATURE 24 - FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR liarelly VR A15 [4] 20 M 1/66



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
- = 0	09719 CERTIFICATE OF DEATH
hours after death. d in by the lueral rs. Peges, 1 and 2 2 houreafter death	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. COUNTY
The later of the l	Cerroll MARYLAND MARYLAND Carroll
The same of the sa	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town)
4 hour led in pers. 72 ho	8. NAME OF HOSPITAL OR INSTITUTION Of not in hospital, give street address) d. STREET ADDRESS . O. IS RESIDENCE DN A FARM?
2 = 8 = 3	Carroll Co General Hospital YES NO 1
erificate be executed within find place of the place remove carbon person and in any event, within	3. NAME DE DECEASED OF First Middle Last A 4. DATE Month Day Year DECEASED OF
ited wi	(Type or print) A
xecuter and col	WINDOWED DIVORCED (July 29/96) - yrs X
be exital time to the control of the	106. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR dring most of working life, even if retired) 12. CITIZEN DF WHAT COUNTRY?
Tcate be e plysiciam please r wal, and in	13. FATHER'S NAME 1 14. MOTHER'S MAIDEN NAME
ertifica din∎ pl Then remova	Edwar L. Davie Betty Robinson
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service)
permit.	Idwin L. Davis proprieter fort
E >2 E	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: Death was caused by:
es that th hysician. migned by urial-transi urial, crem	IMMEDIATE CAUSE (a) Stewarting Bus 1'4"
ires that physic maigne purial-le pu	Conditions, if any, which gave rise to immediate (b)
iaw requir ttending p has belln as the b prior to t	cause (a), stating the DUE TO
The law requires that the or attending physician. cate has benn ligned by truse as the burial-transit ealth prior to burial, crema	
al or ficate or use	YES NO X
HYSICIAN: The land he hospital or attended for use etached for use Dept. of Health p	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)
HYS the 1 the 1 Dea	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE DF INJURY (Home, farm, 20f. (City or town) (State)
oline Police Parter After do be do be do State	
rENDI ained ained nould the	21. I certify that (I) (this hospital) attended the deceased from 1/29, 1966, to 7/30, 1966, that (I) (we) last saw the deceased alive on 7/30 and that death occurred at 7/30 M, from the causes and on the date stated above.
OR ATTEN OR ATTEN IN ET	22a. SIGNATURE 22b. DATE SIGNED
	ATTENDING MED. STAFF M.D. PHYS. DIRECTOR PHYS. 17/50/66 22c. PHYSICIAN'S 22d. ADDRESS
HOSPITAL Page 4 may Firetor, pag director, pag should be fill	NAME (Type) JOHN S. HARSHEY M.D. & welon St. Westminater, and
TO HOSPITAL Page 4 may III FILLE L director, pa should be fill	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
F F	24. FUNERAL DIRECTOR ADDRESS A 25a. REC'D BY REGISTRAR'S SIGNATURE
VR A15 (4)	J. 2 - Muses &: Westminute ml - DATE AUG 2 1956 Minutes Judge
15M 4-64	



	1 .	ı	Division of STATISTICAL	RESEARCH AND RECORDS, 301			01
			69720	CERTIFICATE	OF DEATH		09719
	deoth ond deoth		PLACE OF DEATH		2 USUAL RESIDENCE (When o. STATE—)	e deceased lived, if institution. Residence b. COUNTY	/
	at a see at	H	CITY OR TOWN (If autside carparate limits,	MARYLAND C LENGTH OF STAY IN 16	c CITY OR TOWN (If outside	corporate limits, write RURAL and give	P U L
	haurs after deat in by the funeral irs. Pages I and 2 haurs after deap		write RURAL and give nearest town	19mg	presto	mustu	, ,
	lled in yapers.		S. NAME OF HOSPITAL OR INSTITUTION (If not in ho	ispital, give street address)	d. STREET ADDRESS		B IS RESIDENCE ON A FARM? YES NO
	withir tely fii rban g		NAME OF First DECEASED Type or print) MARTHA	Middle JANF	Lost 84 4	DATE Month OF DEATH JULY	30 1966
	requires that the death certificate be executed within 24 haurs after death g physician. I signed by the attending physician and completely filled in by the funeral buriol-transit permit. Thin page remove carban papers. Pages I and 2 buriol, cremation, or remavely and in any event, within 72 haurs pitel death	<u></u>	6. COLOR OR RACE 7. MA	ARRIED NEVER MARRIED 8.	DATE OF BIRTH	9 AGE (In years IF UNDER 1	YEAR IF UNDER 24 HRS. Doys Hours Min
	be exi	Mo M.r	USUA, OCCUPATION (Give kind of work done ing most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & St		ZEN OF WHAT INTRY?
	ficate t	1	FATHER'S NAME	,	14 MOTHER'S MAIDEN NAM	ester, mil - a	· SG.
	ng mag	16	WAS DECEASED EVER NUS ARMED FORCES?	16. SOCIAL SECURITY NO. 17 IN	Betty FORMANT	Robinson	0 ,
	he deoth cer attending permit. The	(Ye	s, na, ar unknown) ((If yes give war or dates af service		win L. A	There yesten	moter ml.
	equires that the death cer physician. signed by the attending p burial-transit permit. The burial, cremation, or rem		18. CAUSE OF DEATH (Enter on y one cause per PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (o)	line for (a), (b), and (c).) ——————————————————————————————————	Turety	B.W. 12"	ONSET AND DEATH
	equires that the physician. signed by the buriol-transit buriol, cremat		1/6 X DUE TO	D -:	7		
0	phy:		rise to immediate cause (a), Stating the underlying cause	7/Cens	7		
M	law inding been been s the rior to		last. (c)	TO BELLEVIA TO BELLEVIA TO THE STATE OF THE	IS TRAILING BYFRACE COMPANY	Che CIVICE III DADY 34	I 19 WAS AUTOPSY
7	The arter of the has as a	ATTON	PART II, OTHER SIGNIFICANT CONDITIONS CONTRIB	RUSING TO DEATH BUT NOT RELATED TO TH	16 FERMINAL DISEASE CONDITI	ON GIVEN IN PART I(0)	19 WAS AUTOPSY PERFORMED? YES NO
6	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Poge 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detoched for use as the buriol-traishould be filed with the State Dept. of H-olth prior to buriol, cre	CERTIFICATION	20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	205 DESCRIBE HOW INJURY OCCURRED (E	inter nature of injury in Part	I or Port II of item 18.)	
	G PHY the ho r this c detoch te Dept	MEDICAL	20s. TIME OF INJURY Month, Day, Year Haur a.m. p.m. 19		OF INJURY (Hame, farm, ry, street, affice bldg., etc.)	20f (City or town) (Cau	nty) (State)
	NDIN ed by : Afte id be ie Sto		21. I certify that (1) (this haspital) sow the deceased alive on	attended the deceased fram	7/29, 196 death occurred at 7	6, to 7/30, 196 M, fram causes and an th	£, that (I) (we) last
	ATTE etaine CTOR shou shou with the		22a. SIGNATURE	/ - 17 - P, and mar	ATTENDING MEI	22b. DA	TE SIGNED
	L OR v be r DIRE		22c, PHYSICIAN'S	ushing M.D.	PHYS DIR	ECTOR LI PHYS 4	130/66
	O HOSPITAL Poge 4 may 5 FUNERAL director, page		NAME(Type) JOHN S	HARSHEY MD	1 sauch	er St. Westmin	ate and
	TO HO Poge TO FU! Shou	230	BURIAL CREMATION, PEMOVAL (Specify) 8/1/6	23c NAME OF CEMETERY OR CO	retury	Shlim W.	(County) (Store)
	VR A15 (4) 20 M 1/66	24	SUNERAL DIRECTOR	Mestronetic 70	DATE AUG	REGISTRAR 256. REGISTRAR'S SI	
		-			-		11 0



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09721 CERTIFICATE OF DEATH filled in by the funeral n papers. Pages 1 and 2 in 72 haurs after death The low requires that the deoth certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission 1 PLACE OF DEATH o. COUNTY Carroll o. STATE Maryland b COUNTY MARYLAND Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town)
Sykesville 8vrs.lmo.7dvs. Baltimore ottending physician and completely filled in to permit. Then please remove carban papers. e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS 2628 N. Calvert St. Springfield State Hospital NO I YES 3 NAME OF Middle Lost 4. DATE Doy First Year <u>*</u> DECEASEO DILLON 18 eyent, WILLIAM MCCAFFREY JULY 19 66 OEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. 9 AGE (In years S. SEX 6 COLOR OR RACE 8 DATE OF BIRTH 7. MARRIED NEVER MARRIED birthdoy) Months Dovs Hours 5-23-1889 Mala White WIDOWED DIVORCED 10p USUA: OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 8IRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working rie, even if retired) COUNTRY? INDUSTRY U.S.A New York Printer 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, Edmund M. Dillon Virginia McCaffrey 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO permit. (Yes, no, or unknown) (If yes give wor or dotes of service) 122-20-0341 Records. Springfield State Hospital cremotion, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) signed by the buriol-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (c) TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Poge 4 moy be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Generalized arteriosclerosis Years Conditions, if any, which gove rise to immediate couse (a). DUF TO stating the underlying couse as the last. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Schizophrenic reaction, paranoid type detached for use te Dept. of Health NO IC 205 OESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Opy, Year 20d INJURY OCCURRED 20s. PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) of work of work 21. I certify that (I) (this haspital) attended the deceased fram-19-15 AM, fram causes and an the date stated above. 7-18-66 , 19 , that (I) (we) last 6-11-58 and that death accurred at saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE 7-18-66 M.D. DIRECTOR PHYS director, poge should be filed Springfield State Hospital 22d ADDRESS 22c. PHYS+CIAN'S Sykesville, Maryland R. G. Lájonchere, M. D. NAME (Type) 230. BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF (County) (State) Brookyn Anne Arundel July 256 REGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR FUNERAL DIRECTOR 22 1966 20 M 1/66



-4-	*		DIVISIO	M. N OF STATISTICAL R	AKTLAND STATE ESEARCH AND RECO	RDS, 301 W	NENT OF HEA . PRESTON STRI	altin Eet, Baltimore	1, MARYLAND	
- mp	4	1_	09722	2	CERTIFIC	ATE OF	DEATH		09721	
hours after the funeral d 2 should ath.	ME2		PLACE OF DEA	Carrel	MARYLAN	a, STAT		and the same of the same of	Carry	on)
24 ho in by th i and er deatl		-	write RURAL	'N (if outside corporata limits, end give nearest town)	E. LENGTH OF STAY IN	lb c. CITY	11 7	orporate limits, write RUR.	AL and give nearest town)	_
ours aff	ļ	\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	d. NAME OF HO	SPITAL OR INSTITUTION (II not Less) was in	In hospital, give street address) Ly Amel	d. STRE	FI ADDRESS	A	o. 15 RESIDENC ON A FARM YES NO C	AP /
mpletel papers in 72 h			NAME OF	DAISY	Middie	ECKA	4. DATE OF DEAT	52	30 1961	_ ,
and co carbon nt, withi		5.	SEX	11/	ARRIED NEVER MARRIED DOWED DIVORCED	april /	3,1890	9. AGE (In years IF Un last birthday) Mon		-
ertificate ysician emove ny ever		10a do	ne during most of	PATION (Give kind of work 1 working kie, even if refired)	Eun Him	0 000	PLACE (County & State,	or lareign country) 1	2. CITIZEN OF WHAT COUNTY	RY7
o de plante de la		13.	Same	nel Car	ν	14 MOTHE	R'S MAIDEN NAME	atherin	wmith	_
e atlem Then toval, a				EVER IN U.S. ARMED FORCES? (if yes give wer or dates of service		o Ch	arlesD	Mon Wa	estrum tu,	nd
vires the side of				EATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	e per line for (e), (b), end (c).	4-71	muto	70	ONSET AND DEATH	_
aw requing phyon signe-transitement			Conditions, if	any, which \ (b)	arteria. x	scur	210		Contino	2
The I rattend has been burial			gave rise to imm (e), stating the cause last.							
ICIAN spital or tificate se as the or to bu		CERTIFICATION	PART I OT	THER SIGNIF, CANT COND. TIONS	CONTRIBUTING TO DEATH BU	T NOT RELATED TO	THE TERMINAL DISEAS	SE CONDITION GIVEN IN	PART I(a) 19. WAS AUTOPS PERFORMED? YES NO	3Y - Y
PHYS the hos this cer for us for us		CERTIFIC	20a ACCIDENT OR CONTRIBUTI (IF EITHER, NOT	WAS UNDERLYING 206	. DESCRIBE HOW INJURY OCC	URED. (Enter neture	of injury in Part I or Per	rt II of item 18)		_
DING ned by After letached		MEDICAL	20c TIME OF N Hour a.i	m,	28d. INJURY OCCURRED 20e While Not While el work el work	PLACE OF INJUR fectory, street, of	Y (Home, farm, 20f. (Cice bldg., etc.)	City or fown)	(County) (State)	
ATTEN be retai CTOR uld be o			21. I certify	y that (I) (this hospital)	00 1.1	/ /	ured at	om the causes and	on the date stated abo	
L OR RE		,	22a. SIGNATUI	RE CONTRACTOR	terficial	M.D. PHYS.		STAFF PHYS	226 DATI July 30, 1966	E
HOSPITA oth. Page FUNERA sctor, page filed with	ì		22c PHYSICIAI NAME (T)		CVPORTERE	15 LD 226. A	DORESSHAMS	isterd,	190	=
death. Go FUJ directo be file	_		BURIAL CREM REGIOVAL ISPEC SWILL	MATION, 236 DATE THEREOF	23c. NAME OF CEMET	err or cremato	retun Pr	CATION (City, town or	(State)	<u></u>
VR AIS (4) 1SM 7/61	as			TOR'S SIGNATURE	West huma	tu m	DATE AUG	2 1936 F	AR'S SIGNATURE Judge	_
	7	-	0		,	7		- V		

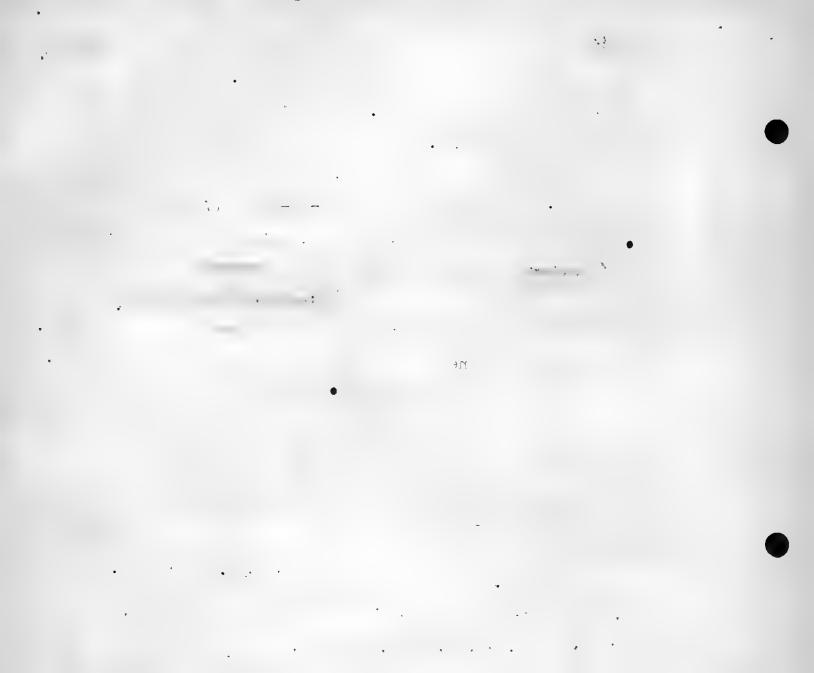
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH filled in by the funeral in papers Pages I and 2 within 72 hours after death. deorth. executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE **b** COUNTY Carroll MARYLAND Maryland Carroll b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Uniontown Westminster 13 days d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Carroll County General Hospital YES NO THE 3 NAME OF First Lost 4 DATE carban Month DECEASED (Type or print) OF 1966 William July 18 Eckenrode DEATH Eugene S. SEX 9 AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS 6 COLOR OR RACE B DATE OF BIRTH 7 MARRIED NEVER MARRIED 80 (in years Months Ogys Hours DIVORCED June 1, 1877 WIDOWED Mala White 10o, US_AL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT please during most of working life, even if retired) INDUSTRY COUNTRY? U.S.A. Maryland Maintenance. Public School physicia requires that the death certifican 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME or removol, George A. Eckenrode Annie Reaver 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) {\(\text{If yes give wor or dotes of service \)} 16 SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Clarence Lockard, Uniontown, Maryland 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-tronsit p PART I. DEATH WAS CAUSED BY: **ONSET AND DEATH** IMMEDIATE CAUSE (o) DUE TO Cerebral thrombonia Conditions, if any, which gave rise to immediate couse (o). DUE TO stoting the underlying couse os the prior to hos been Inst 19. WAS AUTOPSY PERFORMEO? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO O FUNERAL DIRECTOR: After this certificate Ö 20o. ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) Not While at work ot work , 1966, that (1) (we) last 21. I certify that (1) (this hospital), attended the deceased fram wally Si 19 66, and that deoth occurred at 5 33 saw the deceased alive on M. fram couses and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNEO M.D. DIRECTOR 22d. ADORESS 22c. PHYSICIAN'S. NAME (Type) director, p 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b DATE THEREOF REMOVAL (Specify) Church of God Cemetery Uniontown, Maryland 1966 Burial 1966 REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR Mariles 20 M 1/66 DATE O.Fuss & Son. Tanevtown. Md.



	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M	ARYLAND
N# 1	09724 CERTIFICATE OF DEATH	9723
rs. Pages 1 and 2 2 hours after death	1. PLACE OF DEATH 6. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Re 6. STATE Md	sidence before #dmlssion
s alt	b. CITY OR TOWN (If outside corporate limits, write RURAL write RURAL and give nearest town)	and give nearest town
	Sykesville 3 yrs. Baltimore	· /
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	0. IS RESIDENCE
ا'ا_	Springfi ld State Hosp. 3410 Dupont Ave	YES NO T
3	NAME OF First Middle Last 4. DATE Month OF	Day Year
5	(Type or print) Sophi#a Miriam Feldman DEATH TITY 5. SEX [6. COLOR OR RACE] 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In years French 19. AGE (In years 19. AGE (In yea	8 19 66 Lyear he under 24 hr:
	W Name Base Months San Base Months	Days Hours Min.
1		TIZEN OF WHAT
ľ	AT UAITE Duggin	MIRTE
Ĩ	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	/ /
	Michael Stotbey 1 Tobu bed.	ELNIA
1	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT MRS. BELLEKLINE 3902 BUCKINCH, MRS. BELLEKLINE 3902 BUCKINCH,	AM ROAD
=	NO MEMBER MANAGEMENT AND MANAGEMENT	
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscerotic Heart Desease	ONSTITUTE DEATH
	4210	
	Conditions, If any, which by Geheralized Arterioscerosis	yrs.
	gave rise to Immediate DUE TO	37
	underlying cause last. (c) Cerebial Artiriesclerosis	Years
TION		19. WAS AUTOPSY PERFORMED?
EIPA		YES NO
AEDT	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIDUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		nty) (State)
MEDICAL	Hour a.m. p.m. 19 at work at work factory, street, office bldg., etc.)	
1		that (i) (we) las
	saw the deceased alive on July 8 19 66, and that death occurred at 9PM, from the causes and on the	e date stated above
	and definitions.	TE SIGNED 6
	M.D. PHYS. DIRECTOR PHYS. 4	
	22c. PHYSICIAN'S NAME (Type) Rita S.Glahn 22d. ADDRESS Springf. State Hosp.	
2	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or cou	
	PUDTIL LAIMAN ANSHE EMUNAH ALIZ CHAIM DALIIMVKC. MM	RYLAND
1	24. FUNERAL DIRECTOR ADDRESS 253. REC'D BY REGISTRAN 250. REBISTRAN 250.	
	SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. DATE JUL 1 1 1966 Miles	rees judge
	· · · · · · · · · · · · · · · · · · ·	



1 (N	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	09725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09724
HEALTH DEPT.	PLACE OF DEATH COUNTY COUNTY COUNTY COUNTY COUNTY
a + :	Carroll Maryland Carroll
ssary nera ny bi men eath	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
cessary, the funeral 5 may be Department after death.	Westminster 45 yrs Westminster
5 5 5 5 7	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
delay and 3 to 3. Page e State hours	178 Penna. Avenue 178 Penna. Avenue YES NO E
2, ar M3. 172	(Type or print) MILDRED NAOMI FISHPAUGH DEATH July 10 1966
death. If a Pages 1. ith form Find 2 with ent within	5. SEX 6. COLOR OR RACE 7. MARRIEO X NEVER MARRIEO Nov. 3, 1913 9. AGE (In years IFUNOER 1 YEAR IFUNOER 24 Hrs.
Wive Will ar	10a. USUAL OCCUPATION (Give kind of work done of the line) 10b. Kind of Business or during most of working life, even if retired) 10b. Kind of Business or line in Noustry 11b. BIRTHPLACE (State or foreign country) 12c. CITIZEN OF WHAT COUNTRY? Lastview, Carroll Co. U.S.A.
n 18. G along pages in any	13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME
hours ice ald ice ald le page	Samuel Seipp Joanna Deagen
24 00ff 7 7 7 1	15. WAS OFCEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Walter L. Seipp Westminster. I.d.
DEPUTY MED. EXAMINER: This certificate should be executed within ease execute the certificate, writing the word "pending" in pencil laretor. Page 4 should be forwarded to the Chief Medical Examiner's tained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Health or its designated agent, prior to burial, cremation, or moval	18. CAUSE OF DEATH [Enter only one cause of] line for (a), (b), and (c).] PART I. OEATH WAS CAUSE OBY: MMEDIATE CAUSE (a)
TO DEPUTY please ex director, retained f TO FUNERA of Health	238. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 7/13/66 Krider's Cemetery Westminster, RD, Md.
VR A: SME (5)	24. FUNERAL OIRECTOR ADORESS 25a. REC'O BY REGISTRAR'S SIGNATURE JUL 14 1956 Milarles Judge



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09726 CERTIFICATE OF DEATH 09725 law requires that the death certificate be executed within 24 haurs after death. and completely filled in by the funeral remave carban papers. Pages 1 and in any event, within 72 hours after deat 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland o. COUNTY b. COUNTY Carroll Carroll MARY! AND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Westminster Westminster
d. NAME OF HOSPITAL OR INSTITUTION (If not un hospital, give street oddress) e. IS RES DENCE ON A FARM? d. STREET ADDRESS Carroll Co. Gen. Hospital NO -106 Uniontown Road YES 3 NAME OF Middle 4. DATE OF physician and completely to Erst Last Month Doy Yeor DECEASED (Type or print) BELLE FRANKLIN DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years lost birthdoy) Months Dovs Hours 3/20/90 WIDOWED DIVORCED White Female 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11, BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY North Carolina USA f3. FATHER'S NAME 14. MOTHER'S MAJDEN NAME remova James Campbell unknown 17. INFORMANT WAS DECEASED EVER IN ILS. ARMED FORCES? 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dates of service) Vinard Franklin. Manchester, Md no crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (c)) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY NEUMONIA IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove nse to immediate cause (a), DUE TO stating the underlying couse has been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? NEART W NO RTERIO SCLEROTIC this certificate 草 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of Item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour o m Not While O FUNERAL DIRECTOR: After 1966 1966, that (1) (we) last 21. I certify that (I) (this hospital) oftended the deceased from be retained shauld and that death occurred at 4 3 M. from couses and on the date stated above. 1966 saw the deceased alive an STAFF M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should b 23c NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) BURIAL, CREMATION (County) (Stote) REMOVAL (Specify) 7/18/66 Millers Cemetery
ADDRESS 25 Md. Carroll Co. Buria 25o. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 1966 Hammstead, Md. Tipton-Eline

MARYLAND STATE DEPARTMENT OF HEALTH



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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORI	E 1. MARYLAND
M)	09728 CERTIFICATE OF DEATH	09727
	PLACE OF DEATH • COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institute of the country	Carroll
-	b. CITY OR TOWN (if outside corporate limits, write RUR write RURAL and give nearest town) 11 an Chester 6 cuks 12 c. LENGTH OF STAY IN 1b 13 c. CITY OR TOWN (if outside corporate limits, write RUR 14 c. CITY OR TOWN (if outside corporate limits, write RUR 15 c. CITY OR TOWN (if outside corporate limits, write RUR	AL and give necrest town)
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS Long View Nursing Home Inc 61 W Main Street	ON A FARMY YES NO P
3	NAME OF DECEASED (Type or print) Sarah ANN GOODWIN DEATH July	Doy Yeer 4 1966
5	Female White widowed Divorced FEB 3 1884 9. AGE (In years I FU)	NDER 1 YEAR IF UNDER 24 HRS. This Days Hours Min.
	Keyistered Nuise Nursing London England	2. CITIZEN OF WHAT COUNTRY L. S. A
	UNKNOWN - POWELL UNKNOWN	
		West minstel
	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OUE TO DUE TO	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which geve rise to immediate cause (e), staling the underlying cause last.	
ATION		PART I(e) 19, WAS AUTOPS) PERFORMED? YES NO 7
CERTIFICATION	20b. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
MEDICAL	20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm. And While at work et work to the street, office bidg., etc.)	(County) (Stete)
	21. I certify that (1) (this hospital) attended the deceased from 5/19/ 1966, to 1/7 saw the deceased alive on 7/3	., 1966, that (1) (we) la on the date stated above
1	220. SIGNATURE W. H. Toward M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.	22b. DATE SIGNE
=	22c. PHYSICIAN'S NAME (Type) We H FOATU MP - 22d. ADDRESS MAKE (Type) We H FOATU MP - 22d. ADDRESS MAKE (Type) We HEREOF 123c. NAME OF CEMETERY OF CREMATORY 123d. LOCATION (City, lown of	Md 7/4/6
2	BURIAL JULY 8, 1966 MEADON BRANCH CEH. WESTYINSTI	TR MD-
23	John Market Mark	harles Judge



1	Division of STATIS	MARYLAND STATE D FICAL RESEARCH AND RECORDS, 3			AND 21201
I. PLACE OF DEA O. COUNTY OF TOW WATER RANA		CERTIFICAT	8/8/66 mm	,, ,	09728
I. PLACE OF DEA		MARYLAND	2 USUAL RESIDENCE (W 0. STATE Maryla	here deceosed lived, if institut o b. COUNT AN	n Residence before admission)
b CITY OR TOW wate RURAL Sykes	VN (if outside corporate limits and give neorest town) SVIILE	s. c length of stay in 16 Byrs.6mos.21d	c C TY OR TOWN (If out	side carparate limits, write RURA	AL and give nearest town)
d. NAME OF HO	SPITAL OR INSTITUTION (If no	ot in haspital, give street address)	d STREET ADDRESS	25 Bedford St	e IS RESIDENCE ON A FARM?
	gfield State			unty Infirmar	YES NO
3 NAME OF DECEASED (Type or print)	IREN	rst Middle MAY	HAI NES	4. DATE Month OF DEATH JULY	Day Year 28 19 66
S. SEX Female	6 COLOR OR RACE White	7 MARRIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH 7-22-92	9 AGE (In years lost birthday)	IF UNDER 1 YEAR 1F JNDER 24 HRS Months Doys Hours Min.
100 JSJA1 OCCUPA	TION (G ve kind of work done king life, even if refired)	106 KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County &	Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAM	ewife	Own home	Maryland 14. MOTHER'S MAIDEN N	AMF	U.S.A.
					,
ASS S	hanholtz FVER N.U.S. ARMED FORCES?	16 SOCIAL SECURITY NO. 17.	INFORMANT	aiden name unk	nown)
(Yes, no, or unknown	OFVER NUS ARMED FORCES? wn) (If yes give wor or dotes o	of service)	D1 G		** * * * * * * * * * * * * * * * * * * *
	F DEATH (Enter only one ros	se per line for (o), (b), ond (c).)	necoros, Som	ingfield State	INTERVAL BETWEEN
PART I.	DEATH WAS CAUSED BY:	Timenni e			ONSET AND DEATH
4	IMMEDIATE CAUSE	, ,			
Conditions, if	ony, which gove }	(b) Renal failure			Weeks
rise to imme	diote couse (o),	1-1			
stoting the u	inderlying couse	(d Nephrosclerosis			Years
PART II OTHI	R SIGNIFICANT CONDITIONS C		THE TERMINAL DISEASE CON	DIT ON GIVEN IN PART 1(0)	
Chroni	c brain synd: otic reaction	ONTRIBLTING TO DEATH BUT NOT RELATED TO rome associated with	cerebral art	teriosclerosis	, with YES NO [3
200 ACCIDEN OR CONTRIBU	T WAS UNDERLYING TING CAUSE OF DEATH OTHER MEDICAL EXAMINER)	205 DESCRIBE HOW INJURY OCCURRED	(Enter noture of injury in P	ort I or Port II of item 1B.)	
20c TIME OF	INJURY Month, Doy, Yeor r o m.		LACE OF INJURY (Home, form, octory, street, office bldg., etc.)	20f. (City or town)	(County) (Stote)
21. 1 c	ertify that (!) (this hos		1-7-63 , 1	3, to 7-28-66	, 19, that (I) (we) lo
saw th	e deceased alive an	7-2'8-6619, and th	at death occurred at	1 trom causes of	and an the date stated abov
_22o. SIGNA	YPE -7	- (10,	ATTENDING -	MID CTATE	22b. DATE SIGNED
Dr.	subour.	us youlu	M.QPHYS	DIRECTOR L PHYS LA	
22c PHYSIC NAME (Glahn, M. D.	22d ADDRESS Sy	ringfield Starkesville, Mar	te Hospital
23o. BURIAL, CREA		EREOF 23c. NAME OF CEMETERY O	R CREMATORY	23d LOCATION (City or Tow	rn) (County) (State)
REMOVALIS	AL JULY	31.1966 SUNSET MEMOR	TAL PARK	CUMBERLAND,	MD.
24. FUNERAL DIR		Kaglet COMBERLAN	D MTD 2So. REC'D	BY REGISTRAR 2Sb REG	SISTRAR'S SIGNATURE
Kil	It Fresh on	al Home	DATE AL	JG 4 1966 /	Molarles Judges



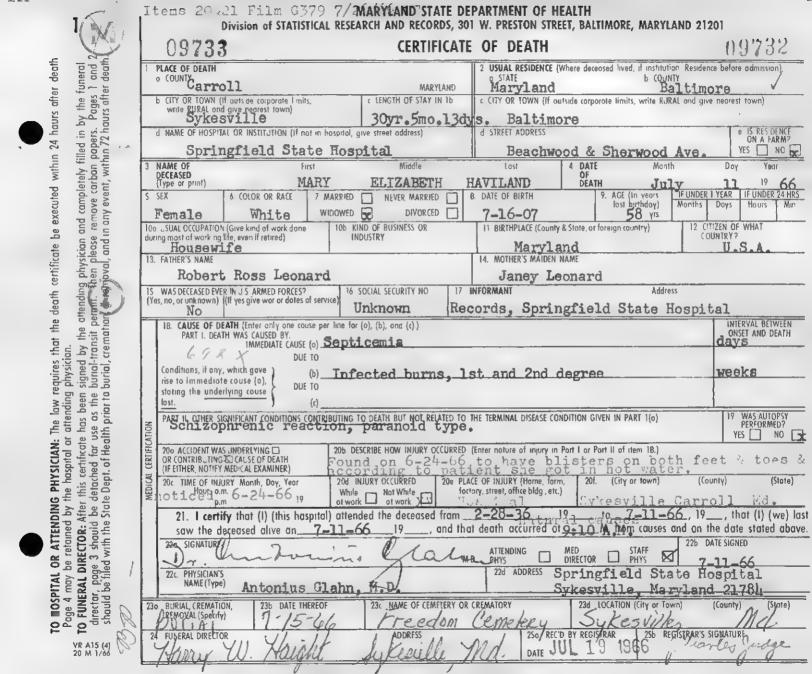
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH burial-transit permit. Then please remave carban papers Pages I and 2 burial, crematian, ar remaval, and in any event, within 72 hours after death. efate be executed within 24 ho≡rs after d∎ath. by the funeral Pages 1 and 2 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) 1. PLACE OF DEATH o COUNTY o. STATE **b** COUNTY Carroll Maryland Carroll MARYLAND b CITY OR TOWN (If outside corporate limits, write RUPAL and give nearest foun)
(Rural) Sykosville, Md. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate (imits, write RURAL and give nearest town) OM Sdays New Windsor 21776 campletely filled in d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Springfield State Hospital Maple Avenue YES NO X 3 NAME OF Middle Lost 4 DATE DECEASED 14 William Oliver Haines 19 66 DEATH (Type or print) S SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH lost birthdoy) Months 10-28-88 white male WIDOWED DIVORCED 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY physician Maryland Laborer 14 MOTHER'S MAIDEN NAME 13. FATHER S NAME John Wesley Haines Laura Nusbaum 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) lift yes give wor or dotes of service) 213-10-7005 Hospital Records no 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
T. Off INTERVAL BETWEEN signed by the burial-transit p ONSEL AND DEATH Left Ventricular Failure IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician DUE TO Arteriosclerotic Cardiovascular Heart Disease years Conditions, if any, which gave (b) rise to immediate couse (a). DUE TO stoting the underlying couse **IO FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. of Health priar ta 1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? Chronic brain syndrome, associated with senile brain disease with YES NO 200 ACCIDENT WAS UNDERLYING OF OR CONTRIBUTING CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER)____ 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year ot work Hour o.m. foctory, street, office bldg., etc.) 21 I certify that 4) (this haspital) attended the deceased from 2-6 7-14 , 1966, that (1) (we) last , 1966_, ta_ 7-14 1966, and that death accurred at u. M, fram causes and an the date stated above. saw the deceased alive on, 22b. DATE SIGNED 220 SIGNATURE STAFF PHYS. 7-15-66 X DIRECTOR PHYS. 22d ADDRESS Springfield State Hospital 22c. PHYSICIAN'S Heinz H. Klaatsch, M.D. NAME (Type) NAME OF CEMETERY OR CREMATORY VR A15 (4) 20 M 1/66 NDJOK DATE JU

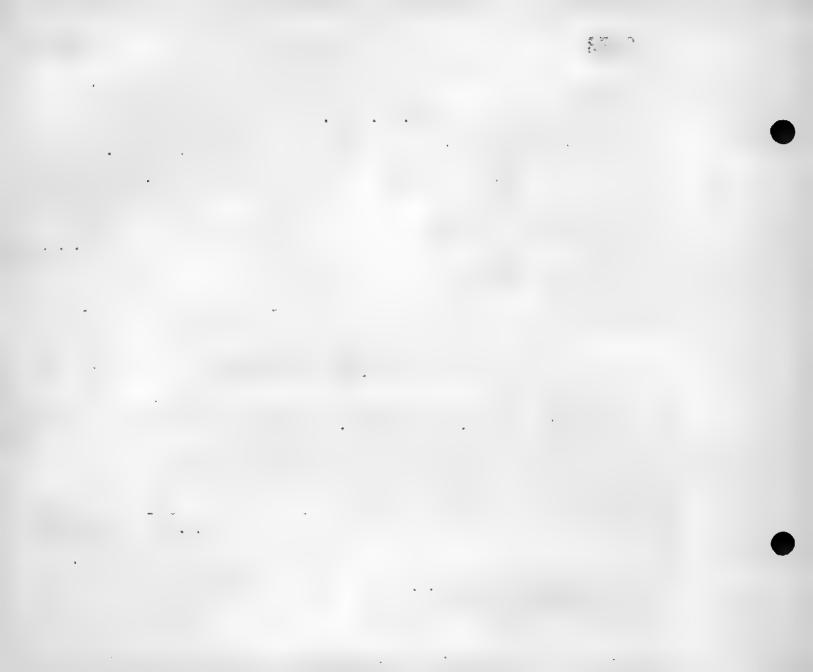


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09731 PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. obysican and completely filled in by the funeral on please remove corbon papers. Pages, and ovol, and in any event, within 72 hours offer the 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) PLACE OF DEATH Carroll b. COUNTY Carroll Maryland MARYLAND b CITY OR TOWN (Foutside carparate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Hampstead Hampstead d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? N. Main St. 128 N. Main St. YES NO IX NAME OF Middie 4 DATE First Lost Month Dov DECEASED 19 66 27 Hale Jacob Housed (Type or print) DEATH B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdov) Dovs Hours Male White 1/20/99 WIDOWED DIVORCED 100 USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Inspector of accits. COUNTRY? Maryland 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME signed by the attending physi buriol-transit permit affigh pl buriol, cremotion, or temovol, Laura Alban Jacob Hale TS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, or unknown) [(If yes give war ar dates of service) 17. INFORMANT 16. SOCIAL SECURITY NO. Address Hampstead. Md. Mrs. Anna Hale no INTERVAL BETWEEN ONSET AND DEATH 1B CAUSE OF DEATH (Enter only one couse per line for (6), (b), ond (c),)
PART (. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been as the lost. 19 WAS AUTOPSY PERFORMED? PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) detached for use te Dept. of Health YES NO I 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year factory, street, office bldg, etc.) Nat White ot wark 1966 to 21. I certify that (1) (this haspital) attended the deceased fram-1966, that (1) (we) last director, page 3 should should be filed with the say the deceased alive an _, and that death accurred at 7 4 M, fram causes and an the date stated above 22b. DATE SIGNED **BIGNATURE** ATTENDING M.D. PHYS DIRECTOR PHYS. 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 23b DATE THEREOF 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 7/29/66 Hampstead ADDRESS Md. Hampstead 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Tipton-Eline Hampstead. Md. 1966

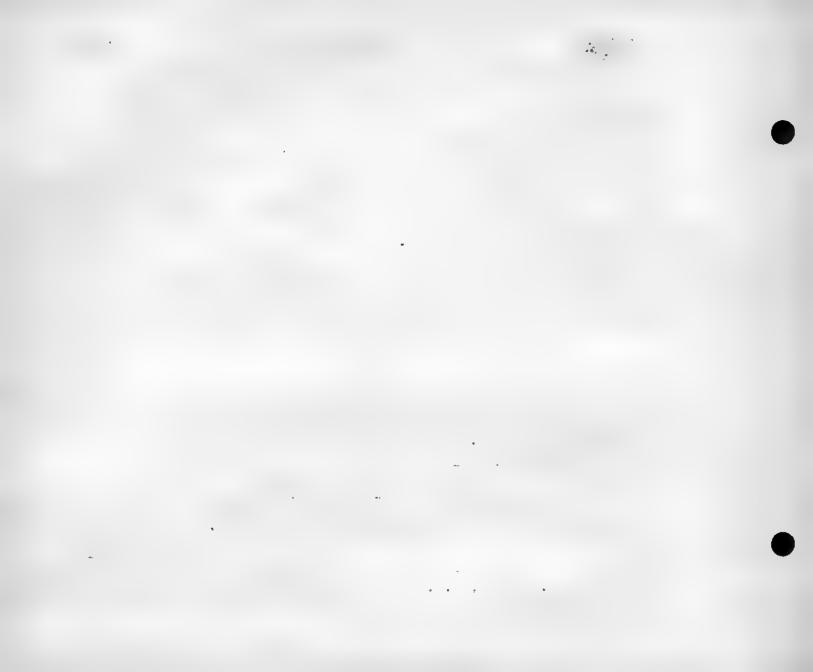
4	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	09732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09731
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
#)	a. COUNTY Carroll MARYLAND a. STATE MARYLAND b. COUNTY Carroll
Series of the series	b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write kukal and give nearest town)
o the funeral of the funeral e 5 may be Department after death.	write RURAL and give nearest town) Westminster Hampstead 06-/
Dep of the office of the offic	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
	Carroll County General Hospital 134 S. Main St.
<u> </u>	3. NAME OF First Middle Last 4. DATE Month Day Year
EXTE HIS	OECEASED (Type or print) LOUISE ESTELLA HARRIS DEATH 7 11 1966
	5. SEX 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.
death. If Pages 1, ith form and 2 with eent within	Female White WIDOWED DIVORCED 10/30/81 84 yrs.
er dea ive Pa with I and event	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
200	HWf Maryland USA
pages In any	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
14 hour litery office pand i	Jacob Rider Christine Miller 15 WAS DECEASED EVER INUS ARMED EDRICES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address
124 in 1 in 1 in 1	(Yes, no, or unknown) ((If yes give war or dates of service)
within pencil in miner's permit.	no 213-30-2030A Mr. T. E. Harris Hampstead, Md.
	PART I, DEATH WAS CAUSED BY:
"pending" in Medical Exa burial-transit	IMMEDIATE CAUSE (a) Confidence of the confidence
d be execu "pending" Medical burial-tran	Conditions, If any, which I (1) It is a state of the stat
De Med Med Med Med Med	gave rise to immediate
ould rid a to the cult	underlying cause last. (c) F-14-66
rte sho e wor he Chi ed as burial	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
the the tree to b	YES NO 🔀
cR. This certificate, writing forwarded to 3 should be agent, prior is	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
writ arde ould pr	
orwo	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20st PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) Hour a.m. p.m. 7 - 4 1966 at work at work work work work work work work work
ne the second se	
the certification of the certi	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion
EXA ne construction of the	death resulted from: Natural causes . Accident , Suicide . Homicide . Undetermined manner .
4 4 3 3	ACTUAL ACTUAL CHIEF MEDICAL EXAMINER 22. DATE SIGNED
	SIGNATURE SIGNATURE DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY
TY SET OF THE SET OF T	EXAMINER'S NAME (Type)
o deputy M please exec director. Pa retained for depute for of Health ou	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
of girls	Burial 7/14/66 Immanuel Lutheran Baltimore Md.
K	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE
VR A15ME 3500 4-64	Tipton-Eline Fun. Home, Hampstead, Md. DATE JUL 15 1966 guarter junger







X	1	_			Division of STATIS		MARYLAND STA ARCH AND RECOR				IMORE, MARYI	AND 21201		
		Alj		29734			CERTIF	ICATE	OF DEATH			091	733	
	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death be retained by the haspital or attending physician. NRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral as should be detached for use as the bitting-transit nermit. Then please remove carbon papers. Pages 1 and 3	er death		CE OF DEATH DUNTY C	arroll		MAR	LAND	d. STATE Mar	yland	osed lived, if institut b. COUI	VTY		n) /
	by the	n any event, within 72 haurs after	ь. с (Ru :	TY OR TOWN (1)	f outside corparate limit give nearest town) Kesville	ts,	Oy Om	16d	c CITY OR TOWN (f autside carpai timore	city	RAL and give nea 21217	-	
	24 hc d in	72 1			AL OR INSTITUTION (If n		,		d. STREET ADDRESS	Do Inno	(7.1		e IS RESID ON A FA	ENCE ARM?
	hin 24 filled	[14]	3. NA/	Spring	field Step	e Hos	pital Middle		Lost	A DATE	Street	h D	YES Yea	
	ecuted with completely	t, wi	DEC (Typ	EASED e ar pant)		Lonzo	(NMN)		Hill	OF DEATH	_		8 19	66
	cuted omply	ever	S SEX		6 COLOR OR RACE	7 MARRIED			DATE OF BIRTH		9 AGE (In years lost birthday) 66 yrs.	Manths Day		
	e exec	any		ale	Negro (Give kind of work done	WIDOWED	DIVORCEI		5-12:50			12 CIT ZEN		
	e be	Se W	quillo u	ngst of working	l fe, even if retired) Ban		NDUSTRY		Mary:		areign (abinty)	COUNTR	TSA	
	ficat ysicio	3		THER S NAME					14. MOTHER'S MAIL				7-021	
	certii) NOL	Wi	lliam	Hill					tep				
	equires that the death certificate be physician. signed by the attending physician ar burial-transit permit. Then please a	n, af re	1S. W. (Yes, no	us deceased eve o, ar unknawn) unknow	R IN U.S. ARMED FORCES? (If yes give war or dates 12	af service)	social security no.		ospital	Records	Addre	955		
	it the a	natia	18	PART I. DEAT	ATH (Enter anty and ca H WAS CAUSED BY.	Α	r (o), (b), and (c)) ute Conges	+i wa	Honnt F	ndluma			NTERVAL BETT ONSET AND D	EATH
	thought the	crer		260	1MMEDIATE CAUSE DUI	(o)	ace conges	CTAE	Hear b F	ATT WITE			WI THUR	-65_
	uires hysic gnec	Juila	Ca	nditions, if ony, e to immediat	a cauca (a)		abetic Cor	18					hours	-
	N: The law requires the or attending physician, or attending physician, other has been signed by the physician of the burial-four	ta bi		ting the under		E TO							histor	r Tr
	endir s ber	riar		_	GNIFICANT CONDITIONS	(c)	iabetes Me	ATED TO 1	HE TERMINAL DISEASE	CONDITION GIV	EN IN PART 1(o)		9. WAS AUTO PERFORME	
	The raft	를 .	NOIL	Chron	ic brain a	syndroi	me, cerebr	al a	rteriosc	lerosi	with		PERFORME YES	ED?
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law rapage 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been director mane 3 should be detached for use me the	State Dept of Health prior to		O ACC DENT WAS	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	205. D	ESCRIBE HOW INJURY O	CCURRED.	Enter nature of injur	y in Part I or Po	ort II af îtem 18.)			
	by the haspital feer this certifical	te Dept			JRY Manth, Day, Year n.	1	INJURY OCCURRED e Not While rk at wark		E OF INJURY (Hame, ory, street, office bldg.	,etc.)	-	(County)	(:	(State)
	DIN J by Afte	Sto		21. I certi	fy that (#) (this ho	spital) atter	nded the deceased	fram	6=22	, 19 66,		19 66	that (乔 (v	we) last
	ATTENE etained CTOR: A	ŧ.	_	30 W IIIC U	eceased alive an_	770	19 <u>66</u> ,	and that	death accurred	ot_4 A.	M, fram causes	and on the d		above.
	OR ATTEND be retained DIRECTOR: A	shauld be filed with the		2a. SIGNATURE	11/2/1/2	Steen		J.M	11111	MED. DIRECTOR	STAFF PHYS.			
	TAL AL D	[] a	2	2c. PHYSICIAN'S NAME (Type	The same of the sa	ngo.	M D		22d. ADDRESS	1.7.2 C4	ate Hos			
	A number	P P	23n B	UR AL CREMATIO			234 NAME OF CEM	ETERY/OR (OCATION (City or To		ntv) (S	jate) ()
	TO HOSPITAL Page 4 may TO FUNERAL I	sha		MOVAL (Specify		12.1960	MASER	/ Le	netery	Elle	no areu	delle.	or	nd,
	VR A1:	5 (4) (0)	24) F	MERAL DIRECTO	Pall !	1211	SON DORESS	th.	ave pso	RECD BY REGIS	1966 25b, RI	GISTRAR'S SIGNA		
	20 M	1.00	10	John	on-reace	436	trance	mi	DATE	7 10	1000 //	Charles	Judge	



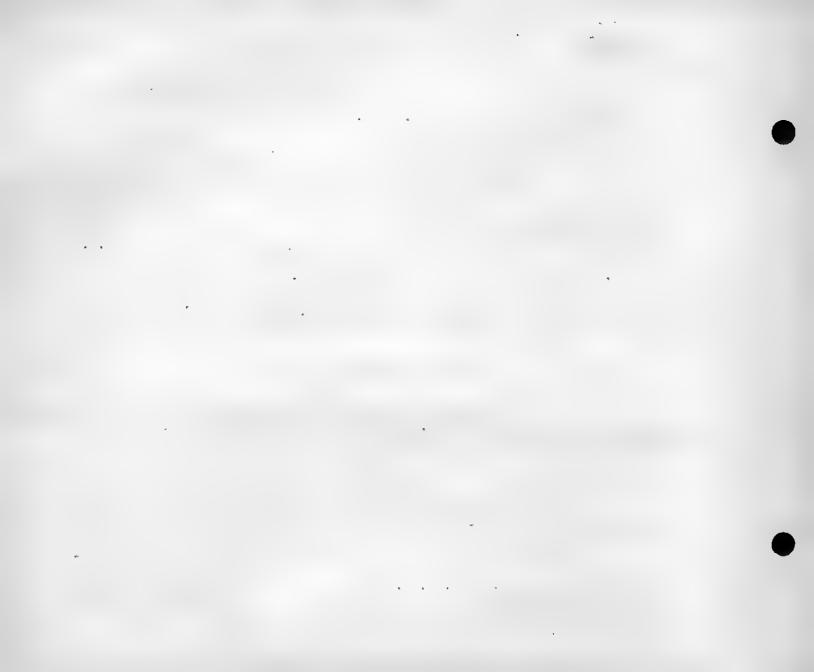
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death, 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institut an: Residence before admission) 1. PLACE OF DEATH o. STATE Maryland Baltimore City o. COUNTY Carroll MARYLAND idiament completely filled in by the fur lease. Pages 1 and in any event, within 72 haurs after b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) C LENGTH OF STAY IN 16 Baltimore Sykesville 500 2da e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Springfield State Hospital 2834 Maryland Avenue YES 🔲 NO 🔽 executed within 3. NAME OF Middle 4 DATE Year Last Day DECEASED RAYMOND CHESTER Julv. 19 66 HILL, Sr. Type or print) DEATH 8 DATE OF BIRTH 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS s SEX 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** last birthday) Days Haurs 7-22-94 DIVORCED WIDOWED White Male 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR pe during most of working life, even if retired)

Engineer (retired)

13. FATHER'S NAME COUNTRY? INDUSTRY offending physidar II.S.A The law requires that the death certificate New York 14. MOTHER'S MAIDEN NAME buriol-transit permit. Then pl buriol, crematian, or removal, Norman Hill Adelaide VanMatter 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, or unknown) (If yes give wor or dates of service) 16 SOCIAL SECURITY NO. 17. INFORMANT Records, Springfield State Hospital Unknown yes INTERVAL BETWEEN ONSEJ AND DEATH 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY Carcinoma of lung IMMEDIATE CAUSE (o). signed by 1 Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Conditions, if any, which gove nse ta immediate cause (a), DUE TO stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? for use Health NO V asocywith cereberal arteriosclerosis with psychotic reaction 205, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port 1 or Port 11 of Item 18.) 20a ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Not While at wark at wark pe 2-18-66 . 19 ta July 2 . 1956 , that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram____ and that death accurred at_ M, fram causes and an the date stated above. saw the deceased alive an_ 22b. DATE SIGNED 22a. SIGNATURE Eduardo R. acel MED. DIRECTOR STAFF PHYS. 7-9-M.D. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesville, Maryland 2178h director, p Edwards R.Acle. M.D 23d. LOCATION (City or Town) 23b. DATE THEREOF (Stote) 23c. NAME OF CEMETERY OR CREMATORY 23g. BURIAL CREMATION REMOVAL (Specify)
Burial Baltimore, Maryland 7/13/66 Woodlawn Cemetery 25b. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR ADDRESS 24. FUNERAL DIRECTOR Charley Judge VR A15 (4) 20 M 1/66 Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202

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1	1	Division of STATISTICAL		ARYLAND STATE DEP ICH AND RECORDS, 301			MARYLAND 21	201
		09736		CERTIFICATE	OF DEATH			09735
funeral for death	1	PLACE OF DEATH O. COUNTY		MARYEAND	o. STATE Marylan	d :	s.county Baltimore	nce before odmission)
hours after by the fu		b CITY DR TDWN (If outside corporate limits, write RURA, and give nearest town) Sykesville		c length of stay in 15 9mos.27dys.	Baltimo	itside corporate fimits, w	rnte RURAL and giv	ve neorest town)
nin 24 ho filled in papers.		d NAME OF HOSPITAL OR INSTITUTION (14 not in hos Springfield State Hosp			d STREET ADDRESS 3332 Dolf	ield Avenu	e	B IS RESIDENCE DN A FARM? YES NO DE
ed within oletely fill carbon pent, within		NAME OF First DECEASED (Type or print) SAMUEI		Middle (NMN)	Lost HIRSCH	4 DATE OF DEATH	Month JULY 2	
e executed with and completely remove carbon n ony event, wi	S		RRIED [DATE OF BIRTH 1-16-1895	9. AGE (In lost birth		Doys Hours Min
ction and completely filled it ease remove carbon paper and in ony event, within 72	dur	ong most of working life, even if retired) Owned grocery store		OF BUSINESS OR USTRY	Bremen.		(Y) 12. C	ITIZEN OF WHAT OUNTRY? •S•A•
certificate be a physicion of their please		FATHER'S NAME Unk.	1		14. MOTHER'S MAIDEN Unk.	NAME		
offending permit, in ion, or services	IS. (Ye	WAS DECEASED EVER IN U.S. ARMED FDRCES? as, no, or unknown) (If yes give wor or dotes of service NO	1217	7-32-8212 Rec	rarmant ords, Sprin	gfield Sta	Address ta Hospi	tal
equires that the dea physician. signed by the atten. buriol-transit permit buriol, cremotion, or		IB. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TD	line for (o	10.4				Interval Between onset and Death Days
		Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse (c) (c)	Neph	nrosclerosis				Years
JING PHYSICIAN: The law riby the hospital or attending kfter this certificate hos been be detoched for use as the State Dept. of Health prior to	ATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTED TO SYNCHOLIC PEACTION	UTING TO	DEATH BUT NOT RELATED TO THE	HE TERMINAL DISEASE (O bral arteri	NDITION GIVEN IN PART OSCIBROSIS) with	19. WAS AUTOPSY PERFORMED? YES NO R
TO HOSPITAL OR ATTENDING PHYSICIAN: Poge 4 may be retained by the hospital or TO FUNERAL DIRECTOR: After this certificate director, page 3 should be detoched for u should be filed with the State Dept. of Healt	A CERTIFICATION	200 ÀCCIDENT WAS JNDERLY NG ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		RIBE HOW INJURY OCCURRED. (I			<u> </u>	
inG PHYSICIA) by the hospital ffer this certifice be detoched for State Dept. of H	MEDICAL	20c. TIME OF INJURY Month, Doy, Year Hour o.m. 19	While of work	Not While focto	OF INJURY (Home, form ry, street, affice bldg., etc.		`	ounty) (State)
TTENDI Jined by OR: Afr Jould by h the St		suw the deceased duve on	attende 0-66	ed the deceased fram_9 19, and that	death accurred at	19 ta 7-20 4:30 M. Mram c	auses and an	, that (I) (we) I the date stated aba DATE SIGNED
D HOSPITAL OR ATTENT Poge 4 may be retained FUNEAL DIRECTOR: A director, page 3 should should be filed with the		22c. SIGNATURE TOLANI 22c. PHYSICIAN'S	(Î	Kurg MD		MED STAI DIRECTOR D PHY ringfield	5 🗷 7	-20-66
O HOSPITAL Poge 4 may O FUNERAL I director, pag should be fill	22-	NAME (Type) Octavio A. F	Ruiz	M. D.	Sy	kesville,	Maryland	
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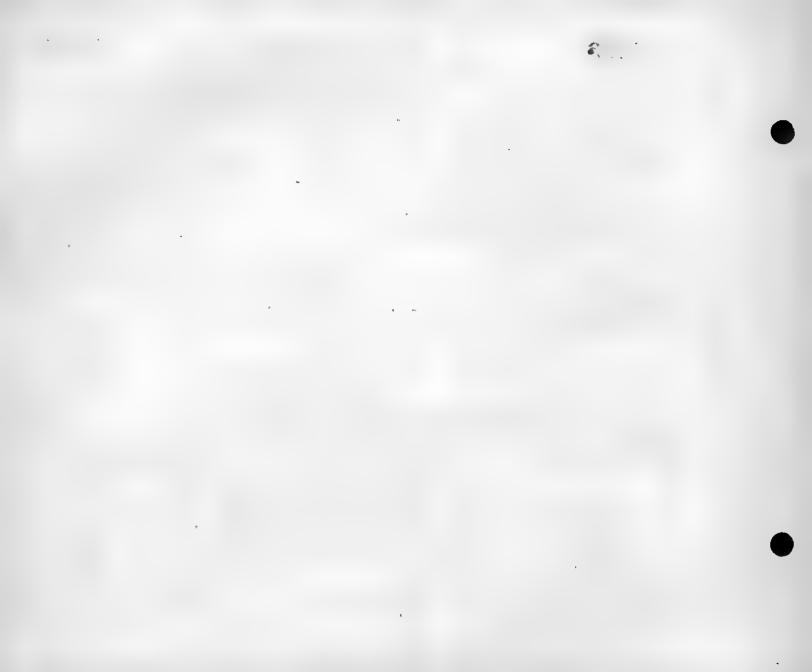
RYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09738 requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY Carroll burial-tronsit pefatte: Then please remove carbon papers. Pages 1 burial, cremation, et removol, and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La7+imora 21.117 filled in e IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? Springfield State Hospital 215 N. Priemo it A.ch YES NO TX First 4. DATE Middle Year DECEASED די בריקוד Windania Tee 71 DEATH 19 (Type or print) IF UNDER 24 HRS S SEX DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Jost birthday) Hours Sep DWORED X " map I p WIDOWED 100 USJAŁ OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY Tirainia 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Willie Mae Peters Rufus Lee - dec. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) [(If yes give wor ar dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT 223-29-(616 1 Stat . Has ital Records INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Full actory insufficient IMMEDIATE CAUSE (6) Page 4 may be retained by the hospital or attending physician. **DUE TO** Canditions, if any, which gave Mar advanced Pulmonary Mulorculosis rise to immediate couse (o), DUE TO stoting the underlying cause O FUNERAL DIRECTOR: After this certificate has been be detached for use as the State Dept. of Health prior to lost. 19. WAS AUTOPS!
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Mt Auburn Cemetry 23d. LOCATION (City or Town)
Baltimore 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) 24. FUNERAL PREGIOR 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66



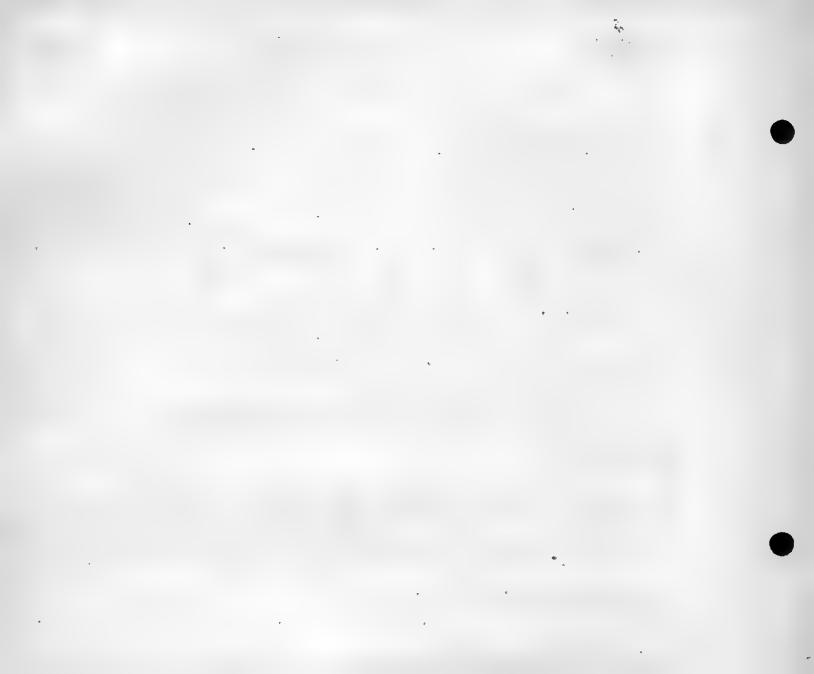
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1203 09739 CERTIFICATE OF DEATH deoth. requires that the death certificate be executed within 24 hours after death physician and completely filled in by the funeral engleses. Pages I and east, and in any event, within 72 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) I. PLACE OF DEATH o. COUNTY Carroll Baltimore City MARYLAND b C.TY OR TOWN (If outside corporate limits, write RUBAL and ame nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) Baltimore 9mos.ldy. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS B IS RESIDENCE ON A FARM? 1135 Parrish St. Springfield State Hospital NO X 3 NAME OF F TS† Middle Lost 4. DATE Month Dov Yedr DECEASED WILLIAM ERNEST **JAMES** JULY 23 66 19 DEATH (Type or print) IF UNDER 24 HRS. S SEX 8 DATE OF BIRTH AGE (In years IF UNDER I YEAR 6. COLOR OR RACE 7 MARRIED NEVER MARRIED Jast birthday) Hours Male Negro Davs 10-30-1894 WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12 CITIZEN OF WHAT 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY Unemployed Virginia U.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unk. Unk. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes no ar unknown) (If yes give war or dates of service) buriol-transit permit buriol, cremation, or 212-26-7178 Records, Springfield State Hospital IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART I. DEATH WAS CAUSED BY: Carcinoma INTERVAL BETWEEN ONSET AND DEATH Carcinoma of the lung IMMEDIATE CAUSE (o). signed by the hospitol or attending physician. 16.5X DUE TO Conditions, if only, which gove rise to immediate couse (a), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been for use os the Health prior to lost. 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO (X) YES . 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED foctory, street, office bldg., etc.) Not While 19 at work be retoined by 21. I certify that (1) (this haspital) attended the deceased fram 10-22-65 saw the deceased glive an 7-23-66 19 , and that death accur 190-15to 7-23-66 _, 19___, that (I) (we) last and that death accurred at M, fram causes and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. 7-25-66 M.D. Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Octavio A. Ruiz. NAME (Type) Sykesville. Maryland director, p 23d. LOCATION (City or Town) NAME OF CEMETERY OR CREMATORY 230. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREOF (County) (Stote) 25b. REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR 24. FUNERAL DIRECTOR





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09741 requires that the death certificate be executed within 24 hours after death. deoth the attending physicion and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission. a. COUNTY o. STATE b COUNTY Carr -11 MARYLAND Maryland

c CITY OR TOWN (H'outside corporate limits, write RURAL and give nearest town) ve carbon papers. Pages 1 event, within 72 hours after b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 Sykesville Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) B IS RESIDENCE ON A FARM? d. STREET ADDRESS Springfield State Hospital YES NO IX 725 Kolly Blue 4 DATE 3 NAME OF First Middle Last Manth Doy Year DECEASED OF DEATH July Kollou Joseph William (Type or print) S. SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Manths Dovs Hours Male WIDOWED DIVORCED TV 7-27-17 10a USUAL OCCUPATION (Give kind of wark dane during mast af working life, even if refired) 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 72. CITIZEN OF WHAT INDUSTRY Elect. Contr. Cumberland Electrician
13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME removo Lucy Violet Kerns John Joseph Kelley WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or gates of service) Ь 220-10-1364 Hosmital Sykeryilla 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c) PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the buriol-tronsit p ONSET AND DEATH Right Ventricular failure IMMEDIATE CAUSE (a) Chronic Pullachary 'nsufficiency DUE TO Conditions, if any, which gave Years rise ta immediate cause (a). DUE TO stating the underlying couse os the l Poge 4 may be retoined by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been TB eld PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? be detached for use Stote Dept. of Health NO X YES 🗌 Alcoholic Addiction 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18.) 20g ACC-DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Day, Yeor 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame farm, 20f. (City or town) (County) (State) Haur o.m. Nat While factory, street, affice bldg., etc.) at wark at work 21. I certify that (I) (this haspital) attended the deceased fram 2014 8 , 19<u>66</u> , ta <u>ລັບໃນ 9</u> , 19<u>66</u> that (I) (we) last director, page 3 should should be filed with the and that death accurred at 11:00M, from causes and on the date stated above. 19 saw the deceased alive an 22b. DATE SIGNED 22a SIGNATURE STAFF ATTENDING X M.D. DIRECTOR PHYS. PHYS 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) Sykasyille, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION 23b DATE THEREOF (Stote) BULLAL (Specify) 7/13/66 SS. Peter & Paul Cem. Cumberland. Allegany 2Sa. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE ADDRESS 24 FUNERAL DIRECTOR VR A15 (4) H. Wayne George Cumberland, Maryland 1966



- 1		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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pape	~	3. NAME OF DECEASED (Type or print) George M. Less 4. DATE Month Day Year OF DEATH 7 2/ 1966
d com		5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR) IF UNDER 24 HRS.
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After After of H		Hour a.m. While Not While lactory, street, ollice bldg., etc.)
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AT AT Suld ate		saw the deceased alive on. 7 21 66.19, and that death occurred at 24.5M, from the causes and on the date stated above.
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MARYLAND STATE DEPARTMENT OF HEALTH



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-	1		Division of STATISTICAL RESEARCH	AND RECORDS, 301 W. P.	PRESTON STREET, BALTIN	IORE, MARYLAND 21201	
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	mpli e co	Ī	5. SEX 6. COLOR OR RACE 7 MARRIED			AGE (In years IF UNDER 1 YEAR	IF UNDER 24 HRS
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	ot the death certific the attending phys nsit permit. Then mation, or removal	Ī	18. CAUSE OF DEATH (Enter only one couse per line top)(o), (i) PART I. DEATH WAS CAUSED BY:	b) ond (c).)	D. C. F.	INTE ONS	RVAL BETWEEN ET AND DEATH
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	TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or ottending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending pays can and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		DEADURAL (C II.)	C. NAME OF CEMETERY OR CREMATO		ATION (City or Town) (County)	, ,
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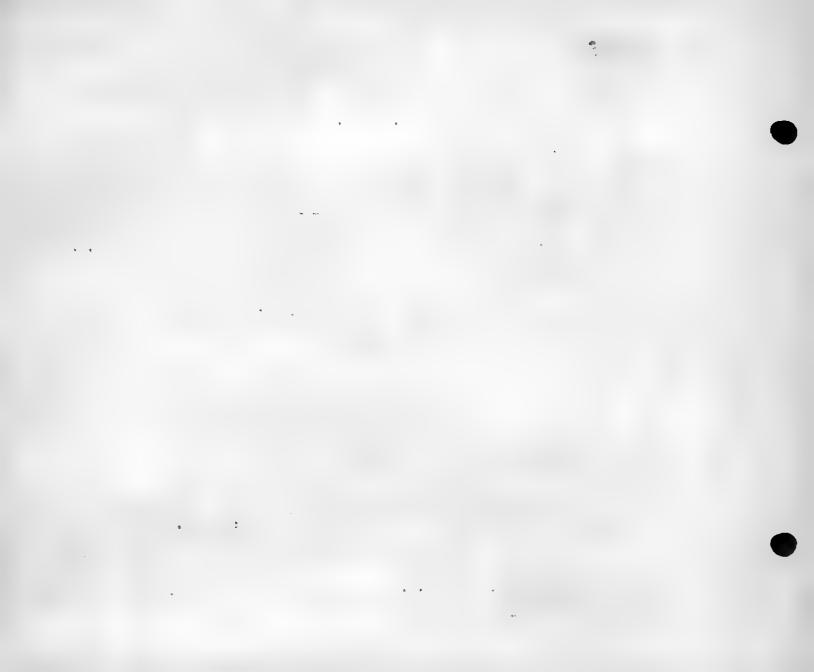
- Toppoon	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND						
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	(Type or prin') 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH Female White widowed Divorced Jan 8, 1881 State of firthday) Widowed Divorced Jan 8, 1881 State of firthday) 100. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (County & Stele, or foreign country) 12. CITIZEN OF WHAT COUNTR						
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*	PART II. OTHER SIGN-FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1,0) PERFORMED? YES NO CONTRIBUTING CONTRIBUTING CONTRIBUTING COURSE. (Enter nature of injury in Part 1 or Part 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CONTRIBUTING CONTRIBUTING COURSE. (Enter nature of injury in Part 1 or Part 11 or Part 12 or Part 12 or Part 13 or Part 13 or Part 14 or Part 14 or Part 15 or Part 15 or Part 15 or Part 16 or Part 16 or Part 17 or Part 17 or Part 17 or Part 18.)	_					
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	21. I certify that (II) (this hospital) attended the deceased from 5 - 2 - 19, 19	/ 0 4					
/	22a SIGNATURE PAULICE C. Perter field MD ATTENDING MED. STAFF PHYS. DIRECTOR PH						
	238. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (Cty, town or county) (State) BEMOVAL (Specify) 9/1/66 Christiana mith-Cemetery Christiana Delawars BELLIAN 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 250. RECO BY REGISTRAR'S SIGNATURE ADDRESS 250. RECO BY REGISTRAR'S SIGNATURE ADDRESS 240 AUG 1966 Christiana Christiana AUG 1966 Christiana C						
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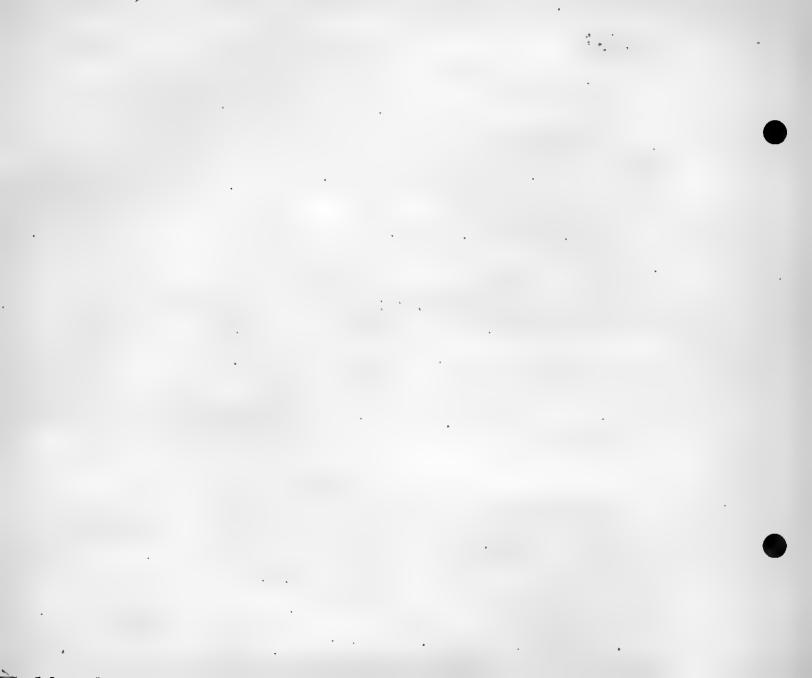
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTI/	MORE 1. MARYLAND
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h. PLACE OF DEATH any View Timery Home on 2. USUAL RESIDENCE (Where deceased lived, I a. SOUNTY	(f Institution: Residence before edmission)
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OF DECEASED (Type or post) AVDE N LIPPY DEATH SU	10 11
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 19. AGE (In year	S IF UNDER I YEAR IF UNDER 24 HRS.
WIDOWED DIVORCED 8/3/1888 P77 yrs.	Months Deys Hours Min.
10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. 8 RTHPLACE [County & Stele, or foreign country done during most of working life, even if relized]	12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME THE Family Home Classes Co. Fa.	U.SA
Augustus Likky mary Hook	
15. WAS DECLASED EVER IN U.S. ARMED FORCES! 16. SOCIAL SECURITY NO. 17. INFORMANT Addre	
[Yes, of unkown] [lfyesgivewerordelesofservice] NONE Rodney P. Neiderer, Hanover	r, Pa. R. D. 4
18. CAUSE OF DEATH [Enter only one cause per line for (e), ,b), end (c),]	ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatu Cioteory tu Caf hip?	Knew 5mm +n.
Conditions, il ony, which) (b) Lynn W. I Cancer - & achierty	Side Indefente
gave rise to immediate causa	vice Singing
(a), stefing the underlying Cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G	IVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
200 ACCIDENT WAS UNDERLYING 1 20b. DESCRISE HOW INJURY OCCURED, (Enter neture of injury in Port Lor Port II of item 18.)	YES NO
20. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Port I or Part II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH UT [IF EITHER, NOTIFY MEDICAL EXAMINER]	
	(County) (State)
20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f (City or town) Hour e.m. While Not While et work el work el work	1/
21. I certify that (I) (this hospital) attended the deceased from 1	8 , 1966, that (I) (we) la
saw the deceased alive on	
222 S GNATURE C. Corter fire M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.	22b. DATE SIGNE
1 22c PHYSICIAN S 22d ADDRESS	July 3, 198
NAME (Type) - Hampstead, Md.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, REMOVAL (Specify)	
Burial 7/21/66 Christ Church Cemetery M. Littles	town, Adams Co. Pa.
24 EUNERAL DIRECTOR'S SIGNATURE) ADDRESS ADDRESS 250. REC'D BY REGISTRAR 256. F	Le layer from
	77 ()



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09746 death 2 requires that the death certificate be executed within 24 haurs after death the ottending wherein and campletely filled in by the funeral sit permit. The profess remove corbon papers. Pages I and nation, or removal, and in any event, within 72 haurs after death 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a COUNTY Carroll a STAFE b COUNTY MARYLAND Baltimore City b (ITY OR TOWN (f autside carparate limits, write RURAL and give neorest town) Sykesville c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 6 mos. 6 dys Baltimore d NAME OF HOSPITAL OR INSTITUTION (If not in baspitol, give street address) B IS RESIDENCE ON A FARM? d STREET ADDRESS Springfield State Hospital 1315 Union Avenue YES No 3 NAME OF Middle DATE Last Day Year DECEASED LOCKNER July (Type or print) JOHN Westey DEATH S SEX 6 COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7 MARRIED **NEVER MARRIED** last birthday) Months Doys Haurs White Male 6-1-74 WIDOWED 10a USUAL OCCUPATION (G ve kind af wark dane during most of working life, eyen if retired) 12 CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) 10b. KIND OF BUSINESS OR INDUSTRY Maryland Painter (retired) 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME cremation, or removol, John Wesley Lockner Unknown WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANI 16 SOCIAL SECURITY NO. Address signed by the ottendii buriol-transit permit. (Yes, no, or unknown) (If yes give war or dates of service) Records, Springfield State Hospital No Unknown INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. ONSET AND DEATH Bronchopneumonia days IMMEDIATE CAUSE (o). DUE TO Conditions, if any, which gave nse ta immediate couse (a), DUE TO as the prior tak stating the underlying cause Poge 4 moy be retoined by the hospital or attending O FUNERAL DIRECTOR: After this certificate hos been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? far use of Health p NO 🚾 20g. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of Item 1B.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year factory, street, office bldg., etc.) Nat While at work at wark 21. I certify that (I) (this haspital) attended the deceased from 12-29-65 7-5-65 . 19..... that (I) (we) last 7-5-66 19 , and that death occurred all \$30 M. For causes and on the date stated above. saw the deceased alive an_ 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS 7-5-66 DIRECTOR M.D. PHYS 22d, ADDRESS 22c PHYSICIAN'S Springfield State Hospital NAME (Type) Octavio A. Ruiz, M.D Sykesyille, Maryland 2178h director, shauld be 23d. LOCATION (City of Tawn) 23c. NAME OF CEMETERY OR CREMATORY (County) 23b. DATE THEREOF (State) 23a. BUR AL CREMATION. ST. MARY'S BALTO, MO. 25b. REGISTRAR'S SIGNATURE 250, REC'D BY REGISTRAR 24 EUNERAL DIRECTOR 1966



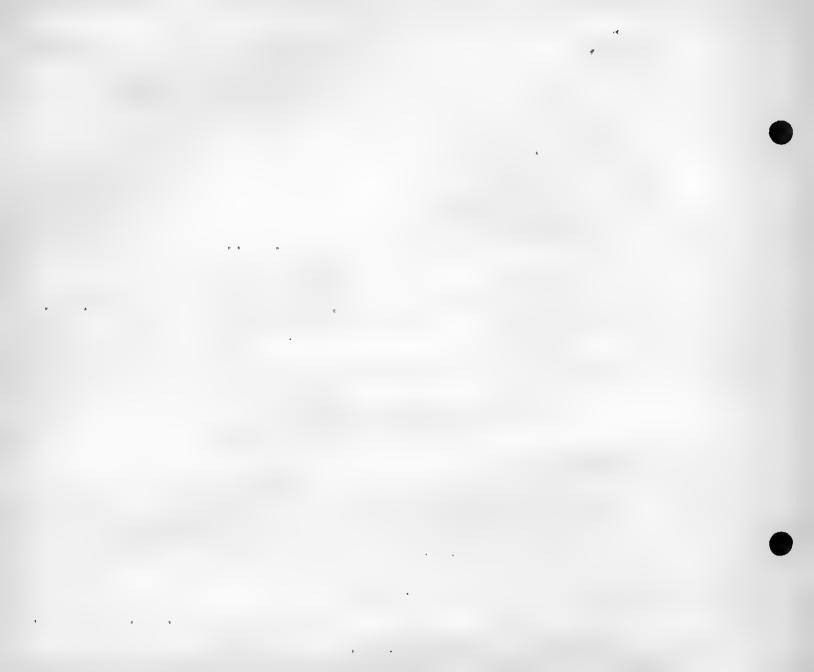
_ 1. <	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, N	IADVI AND
= = ~ 1	09747 CERTIFICATE OF DEATH	9745
after death. the funeral ges 1 and 2 after death	PLACE OF OEATH a. COUNTY a. STATE b. COUNTY county	esidence before admission)
	D. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL	T. City 31
	Sykesville 22 yrs. 9 months Baltinerac	and Bise nearest fown)
24 hours filled in by papers. Papers.	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
· 0.	Springfield STATE Hosp. 1502 S- ANN St.	YES NO
executed within 24 had and completely filled regrove carbon papers and any event, within 72	3. NAME OF First Middle Last 4. DATE Month OF OF DEATH 7	Day Year 23 19 <i>66</i>
we ever	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in years IFUNDER last birthday) Months I	1 YEAR IF UNDER 24 HRS
executed and con regions of any even	MAITE WIDOWED DIVORCED 2.5-09 57 yrs.	
C	during most of working life, even if retired) INDUSTRY ON 1860	DUNTRY?
± ≥ ≥	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	U. S.H.
certifica ding ph Then remova	FRANK MANTIK . STELLA WOZMIAK	
eath certifica attending ph emit. Then on, or removal	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 2 8.0916 49 Springfield Records	
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), 1	INTERVAL BETWEEN ONSET AND DEATH
at the	PART I. DEATH WAS CAUSED BY: Acute Heart Failure	MIN'S
PHYSICIAN: The law requires that the death the hospital or attending physician. this certificate has been signed by the attendetached for use as the burial-transit permit. e Dept. of Health prior to burial, cremation, or	Conditions, If any, which) OUE TO ARTERIOSCLEROTIC HEART Disease	Years
require ding pl been the bu	gave rise to immediate cause (a), stating the DUE TO	7141.5
as base the	underlying cause last. (c) Diabetes Mellitis	Years
SICIAN: The law requirespital or attending posterificate has been ched for use as the both. of Health prior to be.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Schizoph-tivic Reaction - Parancid Type (CHRONIC) 202. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part 11 of Item 18. (IF EITHER, NOTIFY MEDICAL EXAMINER)	19. WAS AUTOPSY PERFORMEO? YES NO 🔀
AN: T ital rtifica i for	Schizoph-twic Reaction - PARANCID Type (CHRONIC) 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18. (IF EITHER, NOTIFY MEDICAL EXAMINER)	
PHYSICIA the hospi this ceri detached e Dept. of		461-1-1
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, left of factory, street, office bldg., etc.) While Not While at work at work at work	nty) (State)
50 ° 0	p.m. 19 at work	that (I) (we) last
L OR ATTENI y be retaine DIRECTOR: age 3 shoul	saw the deceased alive on 7-23 1966, and that death occurred at 145 MM, from the causes and on the	
d w	222. SIGNATURE R. C. fajonolee MB M.D. ATTENDING MED. STAFF 7	- 2 3-66
	22c. PHYSICIAN'S NAME (Type) R (A C NC here 22d. ADDRESS Sering field Hose. Sykes	ville md.
TO HOSPITA Page 4 ms O FUNERAL director, p	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or con	unty) (State)
5 5 5 5	Burn (Society) & July (6 St. Stanislaus (am 6501 Boston S	J. Patto
VR AL5 (4)	24. FUNERAL DIRECTOR ADDRESS DATE JUL 26 1966 John Date JUL 26 1966 John	rley Judge
20M 1/65	1000 S. KENWOOD AVE	00



_ 1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
÷ =«	4	09743 CERTIFICATE OF DEATH 119746
24 hours after death. filled in by the funeral apers. Pages 1 and 2	X 3/1	1. PLACE OF DEATH a. COUNTY a. STATE AA b. COUNTY MARYLAND MARYLAND
rs after by the Pages 1	alle	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town write RURAL and give nearest town)
Sing die	Sinor	AM MERNELL MILLERSVILLE
24 hd filled papers.	72.1	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d. STREET ADDRESS e. IS RESIDENC ON A FARM?
	within 72 hours	Folden age Sult Stowe Scaci Rd YES NO D
death certificate be executed within e attending physician and completely to permit." Then please remove carbon p	ent, wi	NAME OF DECEASED (Type or print) Haryaret March Last 4. DATE Morkin Day Year 19 66
executed and cor	e e	SEX 6. COLOR OR RACE MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 14 HOURS Months Days Hours Min
exec and remi	ı anı	Hamalia White wildowed & Olvorged NOV 22,1883
ficate be e physician in please r	and in any event,	Ga. USUAL OCCUPATION (Give kind of work done lind) 10b. KIND OF BUSINESS OR luring most of working life, even if retired) 11b. KIND OF BUSINESS OR luring most of working life, even if retired) 11c. CITIZEN OF WHAT COUNTRY?
icate phy	<u></u>	13. FATHER'S NAME
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e deal	mation,	Family (INTERVAL BETWEEN
± . ≥ ≅	стета	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and cc).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTERVAL BETWEEN ONSE AND DEATH
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require ding p been the bu	= =	gave rise to immediate cause (a), stating the DUE TO
aw r tend tas b	prior	underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
The land of the la	the state	PERFORMED? YES NO
ICIAN: The law rospital or attend certificate has had hed for use as f	t, of He	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS' PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
L OR ATTENDING PHYSICIAN: " sy be retained by the hospital by the fostital by the hospital by be detached found be detached for the state of the sta		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While Not While
JING d by Afte	Sta	21. I certify that (I) (this hospital) attended the deceased from Figure 2 4, 19 (els, to Fally 9, 19 (els that (I) (we) la
TENI aine OR:	ı the	saw the deceased alive on 1944 9 1944, and that death occurred at 7-45 M, from the causes and on the date stated above
R AT e ret	***	22a. (SIGNATURE) 22b. OATE, SIGNED
	should be filed	22c. PHYSICIAN'S NAME (Type)
TO HOSPITAL Page 4 may TO FUNERAL E	g pin	MIN MY STILL TRANSPORTED TO
Page 1	sho	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Cremation 7/14/66 Vahalla Crematorium St. Louis Mo
		24. FUNERAL DIRECTOR ADDRESS 25a, REC'O BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15 (4)	McCully FH 237 Patapaco Ave 21225 DATE JUL 13 1966 School O
20M 1/6		



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH deoth requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) the ottending physician and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages I and PLACE OF DEATH Maryland Carroll MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 write RURAL and give nearest town) Hampstead Westminster d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Hunter Road Carroll Co. General Hospital YES NO X within 3 NAME OF Middle Lost 4 DATE Month Year DECEASED 0F 1966 MARTIN EDWIN BENTON (Type or print) DEATH S SEX 8 DATE OF BIRTH 9. AGF (In years IF JNDER 1 YFAR IF UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED NEVER MARRIED lost purthday) 2-23-88 Male White WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY INDUSTRY Balto. Co., Maryland Carpenter 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME Keziah Lawson Edward Martin 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 218-01-3328 Mr. Paul Martin Hampstead. Md. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN signed by the buriol-transit p ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove nse to immediate couse (a), DUE TO stating the underlying couse the O FUNERAL DIRECTOR: After this certificate has been last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? NO YES [ृं 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) foctory, street, office bldg , etc.) 19 6 5, that (I) (we) lost 2). I certify that (1) (this haspital) attended the deceased from 7/5 1964 to 19 6 4 and that death accurred at 3 4 M, fram causes and an the date stated above saw the deceased alive on, 22b. DATE SIGNED 22o. SIGNATURE DIRECTOR director, page 3 should be filed v M.D. 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) 23d. LOCATION (City or Town) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION, (Stote) 7/6/66 Md. Salem EUB Cemetery Balto. Co. 2So. REC'D. BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) Tipton-Eline Hampstead. Md. DATE



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M	ADVI AND
ع الحراث ا	69750 CERTIFICATE OF DEATH	09748
executed within 24 hours after death and completely filled in by the funeral remove carbon papers. Pages 1-and 2 any event, within 72 hours after weath.	1. PLACE OF DEATH a. COUNTY ARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: R a. STATE b. COUNTY ARYLAND	esidence before admission)
irs after by the Pages urs aft	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	and give nearest town)
24 hou filled in apers.	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 2.2 2.3 2.4 2.4 2.5 2.5 2.7 2.7 2.7 2.7 2.7 2.7	e. IS RESIDENCE ON A FARM?
vithin letely i rbon p	3. NAME OF DECEASED (Type or print) WOERNER Middle MCKINSEY OF DECEASED (Type or print) WOERNER MCKINSEY OF DEATH OF DEA	Day Year
executed within and completely remove carbon in any event, with	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years Funder last birthday) Months	19 66 1 YEAR IF UNDER 24 HRS. Days Hours Min.
	10a. USUAL OCCUPATION (GIVE kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. C	ITIZEN OF WHAT
	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME	.S.Q.
eath certifical attending ply ermit. Thenali	Tolger Inc Amoly Jame H. Dungar 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17, INFORMANT Address	N
e death ce the attend it permit. lation, or 17	(Yes, no, or unkeinth) (If yes give war or dates of service) 067 - 09-95/3 Mis Wolmer Mc Kinnely 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	addilsa INTERVAL BETWEEN
ires that the death certifics physician. r signed by the attending pl burial-transit permit. Then burial, cremation, or remova	PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	ONSET AND DEATH
ires the signal of signal of signal of the s	Conditions, if any, which gave rise to immediate (b)	17yun
CAN: The law requires that the ospital or attending physician. Certificate has been signed by hed for use as the burial-transit. Certificate has the burial-transit.	cause (a), stating the underlying cause last.	
The lation at icate hor use lealth p	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Contribution of the part is of item 18. 20a. ACCIDENT WAS UNDERLYING THE CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 of Part 11 of Item 18. (IF EITHER, NOTIFY MEDICAL EXAMINER)	19. WAS AUTOPSY PERFORMED?
PHYSICIAN: The Is the hospital or at this certificate detached for use to Dept, of Health)
ING PHYSI I by the hu After this I be detack State Depi	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (Country a.m. p.m. 19 At work at work at work	inty) (State)
OR ATTENDING be retained by JIREDTOR: After ge 3 should be		c, that (I) (we) last
OR ATT OR ATT / be reta DIRECTO	22a. SIGNATURE ATTENDING MED. STAFF 22b. D M.D. PHYS. DIRECTOR DPHYS. 7/6	ATE SIGNED
O HOSPITAL OR ATTENDING IN Page 4 may be retained by the Foreign of Funeral. Directors, after director, page 3 should be should be filed with the State.	22c. PHYSTOIAN'S NAME (Type) JOHN S. HARSHEY M.D. 22d. ADDRESS NAME (Type)	noter had
TO HO Page	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or con BEMOVAL (Specify) 7 5 6 700 100 100 100 100 100 100 100 100 100	inty) (State)
VR A15 (4)	24 FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR	S SIGNATURE
15M 4-64	The state of the s	They judge



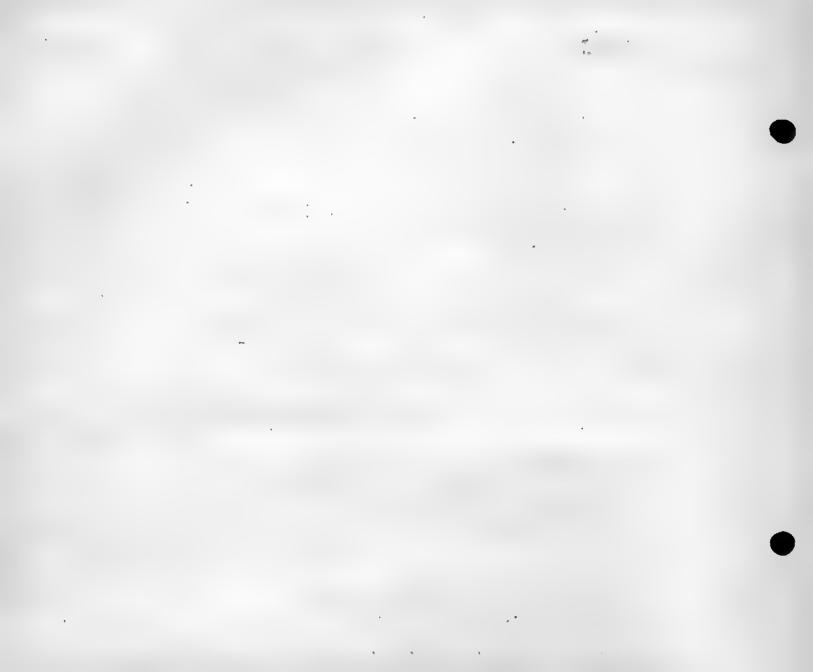
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) e. COUNTY b. COUNTY a. STATE Carrell Maryland MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b funer may b Sykesville Davs Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS **B. IS RESIDENCE** ON_A FARM? ay to Page State hours Springfi 1d State Hospital YES 1 Glenallen Ave NO . NAME OF Middle DATE Month Year DECEASED 0F Mizabeth DEATH (Type or print) 19 Anna Mown 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED DATE OF BIRTH AGE (In Years I FUNDER 1 YEAR HE UNDER 24 HRS last birthday) Months Davs Hours Female White WIDOWED I DIVORGED F 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) COUNTRY? Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no. or unkown) (If yes nive war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 4.4440 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last WAS AUTOPSY PERFORMED? YES NO N 25 0 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) should be forwarded PRIMARY TO OT CONTRIBUTING CAUSE OF DEATH. 필급 MEDICAL 20d. INJURY OCCURRED, 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Day, Yeer factory, street, office bldg., etc.) While Not While at work ESVILLE 21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion Inspection 1. death resulted from: Natural causes Accident XI. Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SICNED ASSISTANT MEDICAL EXAMINER SIGNATURE for DEPUTY MEDICAL EXAMINER **EXAMINER'S** director. retained NAME (Type) NAME OF CEMETERY OR CREMATORY LOCATION BURIAL, CREMATION, 23b. DATE THEREOF oto Montromeny 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 1331 ROCKVI LADDRESSKE 24. FUNERAL DIRECTOR hanles Tyson Wheeler Rockville, Marvland VR A15ME 3500 4-64



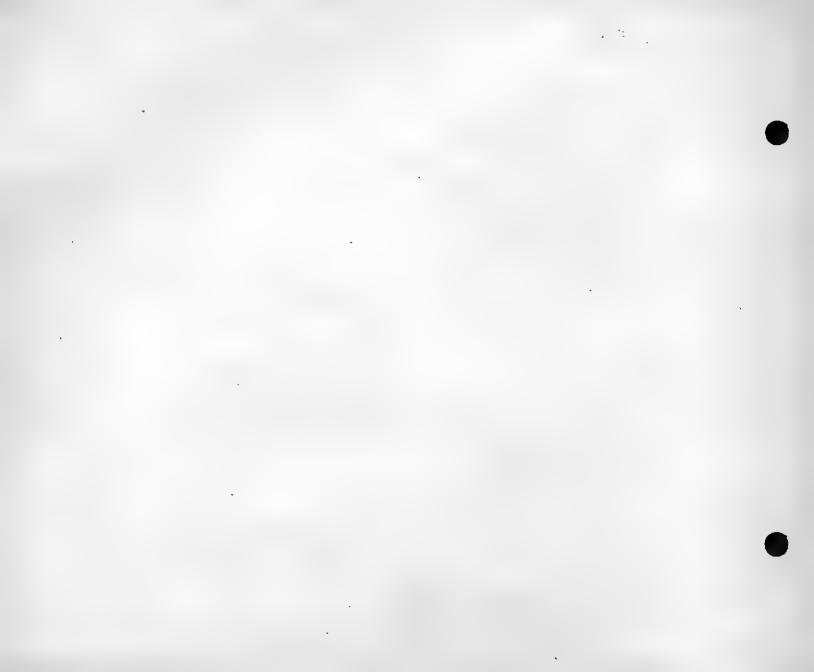
1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M.	ARVI AND
£ 804£	09752 CERTIFICATE OF DEATH	9750
death.	1. PLACE OF DEATH a. CDUNTY b. COUNTY b. COUNTY	sidence before admission)
the after	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL a	ARRO //
hours after in by the same after hours after aft	Sykesville / day Rural Woodhine	and green nearest term,
24 hours after death. filled in by the funeral papers. Pages 1 and 2 in 72 hours after death.	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
within 24 hetely filled roon paper, within 72	3 NAME DF First / Member Last 14. DATE Month	YES NO Y
withi	DECEASED (Type or print) STUART H. Miler DEATH JULY	7. 1966
executed with and complete series cartinally exent,	5. SEX 6. COLDR DR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years) IF UNDER Last birthday Months I	YEAR IF UNDER 24 HRS. Days Hours Min.
e exect an and e remo	10a, USUAL OCCUPATION (Give kind of work done) 10b, KIND OF RUSINESS OR 117 RISTHELES (Country & State, or fereign country) 12. CIT	TIZEN OF WHAT UNTRY?
ate be nysician please I, and ir	Onknown - Self Employed: MARYIAND	JINTRY?
tifficat moval,	13. FATHER'S NAME UNKNOWN 14. MOTHER'S MAIDEN NAME UNKNOWN	
attendin	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. 17. INFORMANT Address (Yes, no, or unknown) [(If yes give war or dates of service)]	
death e att perm ion, c	Unknown ? 578-12-6/06 MR. Robert Killett Sykesville	
requires that the death certificate be executed within ding physician. been signed by the attending physician and completely the burial-transit permit. Then please remove carbon part to burial, cremation, or removal, and in any event, within the burial, cremation, or removal, and in any event, within the burial.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). 1 PART I. DEATH WAS CAUSED BY: In part of the control of the contro	INTERVAL BETWEEN ONSET AND DEATH
es that the physician. signed by urial-transi urial, crem	DUE TO A C. C. C.	100000
uires thi g physic en signe burial-to burial-to	gave rise to immediate (b) Algheri Oschiertie Cupper Hurane	16 ofter
	cause (a), stating the underlying cause last. (c) DUE TD Cause (d) Conveniently Oliseane	10 eys .
CIAN: The law ospital or atten certificate has hed for use as to the for use as to the for use as the formula of the formula o	PARTII. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) ACCIDENT WAS UNDERLYING TO CAUSE OF DEATH OR DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) (If EITHER, NOTIFY MEDICAL EXAMINER)	19. WAS AUTOPSY PERFORMED?
CIAN: The la ospital or at certificate h hed for use t. of Health	20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	YES NO M
HYSICIAN: he hospital this certific etached fo Dept. of H		40444
ING PHY I by the After this be deta State De	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) While at work at work at work	nty) (State)
ENDIN ained b DR: Aft rould b the St	21. I certify that (I) (this hospital) attended the deceased from Aug 2, 1962, to July 1, 196	that (D (we) last
ATTENI retaine CTOR: shoul	saw the deceased alive on 1966, and that death occurred at 75 M, from the causes and on the	e date stated above.
TAL OR ATTENDING may be retained by AL DIRECTOR: After ; page 3 should be be filed with the Stat	Lau Chufman M.D. ATTENDING MED. STAFF 7.	9.66
O HOSPITAL OR ATTENDING PHYSI Page 4 may be retained by the hi O FUNERAL DIRECTOR: After this director, page 3 should be detacl should be filed with the State Dep	22c. PHYSICIAN'S NAME (Type) Saui Okutman 22d. ADDRESS Sykesui'lle	, Hd.
TO HOSPI Page 4 O FUNER director, should b	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or cour REMDVAL (Specify) 7-9-1/4 Freedom Competers Sykesville	nty) (State)
B	24. FUNERAL DIRECTOR ADDRESS 250. REC'D BY REGISTRAR 250. REGISTRAR 250.	SIGNATURE
VR A15 (4)	Harry U: Haight Sykesville, Md DATE JUL 12 1900	0



MARYLAND STATE DEPARTMENT OF HEALTH



4 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
		09754 CERTIFICATE OF DEATH		
funeral de	1.	PLACE OF DEATH 11 2 [ISUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		
/ to order /		e. COUNTY arrell MARYLAND a. STATE b. COUNTY CASSALL		
by the Pages Aurs affer	<u> </u>	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)		
hours d in by rs. Pa	4	d. NAME DE HOSPITAL DR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS (e. IS RESIDENCE		
24 fille pape in 7		267 Valen Road 267 Vales Road VES NO P		
executed within and completely remove carbon I any event, with	3.	NAME OF First Middle Lest 4. DATE Month Day Year		
rted within completely we carbon event, with	5.	Type or print)		
xecuter and col	٠.	Alacade 100 fr. MINONED TO DIVORCED TO AND MIN.		
e be executivistician and confidence removes and in any confidence.	10	AUSUAL OCCUPATION (Give kind of workdope) 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (County & State, or fereign country) 12. CITIZEN OF WHAT COUNTRY?		
te be ysiciar ylease , and i	1	was line worked in Sewing Suchen West minder mind U.S.a.		
ertificat ding phy offien p	13.	FATHER'S NAME A MOTHER'S MAIDEN NAME A THE STATE STATE A STATE STATE A STATE STATE A STATE STATE A STATE		
n certificate be entitle of the certificate be entitle of the certificate of the certific	15	WAS DECEASED EVEN IN U.S. ARMED FORCES? 19. SOCIAL SECURITY ND. 17. INFORMANT Address		
that the death certificate sician. Indeed by the attenting physical transit permitted by the attention of cenoval, are al, cremation of cenoval, and	(11	es, no, or unkown) (If yes give war or dates of service) 216-01-6089 my Clayton 2. myers. address		
the d y the sit p		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH ONSET AND DEATH		
hat tician. led b		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema 7 Junes 2 hours		
physical signal		Conditions, If any, which) DUE TO (b) Right heart & acluse 10 hours		
fing ling been the t		gave rise to immediate operation cause (a), stating the DUE TO		
law ittenuti	NO	underlying cause last.) (c) COCCOMO CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONS IVEN IN PART 1(a) 19. WAS AUTDESY		
The cate ruse ealth	CERTIFICATION	PERFORMED? YES NO Z		
IAN: spital ertifi of H	ERTIF	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Pert II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
PHYSICIAN: The law requires that the hospital or attending physician. This certificate has been signed by detached for use as the burial-transe bebt, of Health prior to burial, cre		(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)		
oy the ter the de de de de	MEDICAL	Hour a.m. p.m. While Not While at work at work at work at work at work		
TENDIN Tained I Tooks Af Toold b	_	21. I certify that (I) (this hospital) attended the deceased from 19 40 on 7-3 1966, that (I) (we) last		
ATTE retail CCTOR sho rith t		saw the deceased alive on 2-3 1966, and that death occurred at 20 M, from the causes and on the date stated above.		
OR OIRE		ELBillings Ca M.D. ATTENDING I MED. STAFF 7-4-44		
RAL RAL be fi		22c. PHYSICIAN'S NAME (Type)		
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death eage 4 may be retained by the hospital or attending physician. TO FUNERAL OIRECTOR. After this certificate has been signed by the after director, page 3 should be detached for use as the burial-transit permits should be filed with the State Dept. of Health prior to burlal, cremations of	23	CHOILINGSIES WESTATISTEN, ITE		
5 5 5 2 8		BELLINA (Specify) 7/6/66 Westminster Cimelia Red Westminster Ad		
(3)	24	ADDRESS 252, RECOUNT 25b. REGISTRAR'S SIGNATURE		
VR A15 (4) 15M 4-64	_	J. E. Myers, p-, west minder to fore JUL 6 1966 get orles Judge		



	14	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
parties and			09755 CERTIFICATE OF DEATH	0.0753			
funera	1 24	1.	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, if institution.	Residence before edmission)			
90	\d /	L	Carroll MARYLAND Md. Balton	rare to			
by th	op h		b. CITY OR TOWN (if outside corporate limits, write RURAL e write RURAL and give nearest lown)	nd g ve neeres lown)			
Pě	afte s	,	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give style) eddress, d. STREET AGORESS	a. IS RESIDENCE			
	hours	2	Long Vew Dersing Home Suc. Thornton Hill YCRK	RD. YES NO I			
complete	72	3.*	NAME OF First Middle Last 4. DATE Month OF OF DECEMBED (Type or print) DEATH	Dey Yeer			
and con		<u>-</u> 5.	SEX 6. COLOR OR RACE 7 MARRIED EXISTED MARRIED 8. DATE OF SIRTH 19. AGE tin years IT UNDER	29 19 CLI YEAR OF UNDER 24 HRS.			
	놭		DIVORCED 6/24/1891 lest birthdey) Months	Days Hours Min.			
ysician remove	e >	10a de	fone during most of working life, eyen if relifed)	TIZEN OF WHAT COUNTRY?			
7 7 6	E 2	13.	Factory Worker Stack + Weeks Dalbo Co. 114/14nd	U > 1-			
tending	0	1	Micholas Stevenson Jarah Robinson	V			
after	(I)	15! {Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address Address	has said			
an. y the	remo		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]	MITERVAL BETWEEN			
ysici	, o		PART I. DEATH WAS CAUSED BY: Myccarhal Infaction	ONSET AND DEATH			
sign	nation		4 DUE TO TELESTATE DISTORTE	11			
endir been been	cren		Conditions, if easy, which gave rise to immediate cause (b) Interest the interest that the cause (a) the cause (b) Interest the interest that the cause (b) Interest the interest that the cause (b) Interest the interest that the cause (b) Interest the cause (b) Interest that the cau	- Jung			
or att	urial,		(a), stehng the underlying DUE TO cause lest. (c)	_			
ital i	3 5	TION	PART II. OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PA	PERFORMED?			
hosp	prior)	IFICA	2De. ACC DENT WAS UNDERLYING [] 2Db. DESCR BE HOW INJURY OCCURED. Enter nature of injury in Pert Lor Pert Lor Item 18.]	YES NO			
	alth The	CERTIFI	OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
Affer the state of	F F	MEDICAL	20c. TIME OF INJURY Month, Dey, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f. (City or fown) (Company) (Com	ounty) (Stere)			
O et alin a	 	W	p.m. 19 at work et work	that (I) (we) last			
S C S	a se		saw the deceased alive on 1242 1960 and that death occurred at 1. M., from the causes and on				
	5 2		220. S GNATURE ATTENDING MED. STAFF	22b. DATE S GNED			
20 20 20			22c. PHYSICIAN'S	and i			
ath. Pr			NAME (Type) Maurice Forterfield M.D. Main Street Hampstead	Maryland			
		234	136. BURIAL, CREMATION 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or could be provided by the control of the country of the count	nty) (Slete)			
VR A15	(4)	24	4 FUNERAL DIRECTORS SIGNATURE ADDRESS 256. REC'D BY REGISTRAR 256. REGISTRAR'S	SIGNATURE			
15M 7/	61	Ι,	John Kurm Sons, Touson, Med. DATE AUG 2 1956 701	carles Judge			
		- li		0			



	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAI	RYLAND
	09756 CERTIFICATE OF DEATH	9754
_ =	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence of the country	dence before admission)
1	a. COUNTY Carroll MARYLAND a. STATE Maryland b. COUNTY Carro	oll
Γ	b. CITY OR TOWN (if outside corporate limits, write RURAL end write RURAL and give nearest town)	d give nearest town)
_	Finksburg 40 yrs Finksburg	3 /
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
		YES X NO
	3. NAME OF First Middle Last 4. DATE Month OF OF OF DECEASED (Type or print) JOHN EDWARD PEELING DEATH July 2	3 1966
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years FUNDER 1YI hale white widowed Divorced Nov. 18,1896 9 wrs.	EAR IF UNDER 24 HRS. Hours Min.
1	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZ	ZEN OF WHAT
n	metal worker in airplane factory Carroll Co., Maryland U.S	itry?
	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
	James Albert Peeling Estella V. Barnes	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 20. 0.7 1.000	
	yes WI 212-03-4007 Mrs. Martha C. Peeling - same	
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).1 PART I. DEATH WAS CAUSED BY: Care in companies of c	NTERVAL BETWEEN ONSET AND DEATH
1	/ / MMEDIATE CAUSE (a) Cal CIROMALOSIS	1 yr
ı	conditions, if any, which } Carcinoma of bladder & colon	3 yrs.
ı	gave rise to immediate cause (a), stating the DUE TO	
١.	underlying cause last. (c)	
OUT OF	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port 11 of Item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	19. WAS AUTOPSY PERFORMED? YES NO X
A TRACTOR	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of Item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTLEY MEDICAL EXAMINER)	
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4 While at work at work 20f. (City or town) 20f. (City or	(State)
1	21. [certify that (I) (this house the deceased from 7-2-65 19 to 7-23-66, 19	, that (I) (We) last
	saw the deceased alive on $7-22-66$ 19 and that death occurred at $5:10$ M, from the causes and on the	date stated above.
	220. SIGNATURE ATTENDING MED. STAFF	
	M.D. ATTENDING MED. STAFF DIRECTOR PHYS. 7-25	5-66
	NAME (Type) D. D. Caples, M. D. 6 Hanover Rd., Reisterstown, M.	
1	burial (Specify) July 27,1966 Greenmount Cemetery Baltimore, Marylan	nd
	24. FUNERAL DIRECTOR J. S. Myles, Jr., Westmirster 722. DATE JUL 28 1996	IGNATURE
12		



	00101	ORDS, 301 W. PRESTON STREET, BALTIME ATE OF DEATH	0975
1.	PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where decessed lived, If	
	Carroll Manylan	Maryland b. cour	Carroll
	b. CITY OR TOWN (if outside corporete limits, write RURAL end give nearest town)		
	Rural Tanevtown	Rural Taneytown	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address)	d. STREET ADDRESS	e. I
1			YES
3.	NAME OF First Middle	Lest 4. DATE Mont	-
	DECEASED (Type or print) Martin Luther Hess Res	OF DEATH T. J	0.5
5.	SEX MARTIN Luther Hess Rea	IVET July B. DATE OF BIRTH 9. AGE (in years	25 IF UNDERT YEAR IF UN
		iasi birinday)	Months Days Hou
10	MICHO INTILLOC	July 10, 1888 78 yrs. USTRY: 11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHA
d	one during most of working life, even if retired)		
12	Farmer Own farm	Maryland	U.S.A.
13	. FATHER S NAME	14. MOTHER'S MAIDEN NAME	
-	Franklin Reaver	Ida Hess	
15 (Y	WAS DECEASED EYER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. es, no, or unknown) (Ifyesgivewerordalesofservice)	17. INFORMANT Addres	
	No 215-34-2804	Mrs. Lina Reaver, R #1, Lit	ttlestown, P
	1B. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c) }	A	INTÉRVAL ONSET A
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6)	- Occhision	سلا
	t At. DUE TO	-t 11 A	
	Conditions, if any, which \ (b) Welevies sell	rolle Heart Riseas	义 /1.
	gave rise to immediate cause (e), stetling the underlying DUE TO	A T	
	cause last.	Willeriosclerosis	10 4
Z	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO SEATH BL	T NOT RELATED TO THE TERMINAL DISEASE CONDITION GI	VEN IN PART 1(a) 19. 19.
CERTIFICATION	Maria : Pulmonny	Parokusomo : anomi	1, 2 YES T
THE	200 ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCC	URRED / Enter nature of injury in Pert I or Pert II of item 18.)	
8	OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
13	20c. TIME OF INJURY Month, Day, Yaer 20d. INJURY OCCURRED 20e	. PLACE OF INJURY (Home, farm, , 20f. (City or lown)	(County)
WEDICAL	Hour a.m. While Not While et work at work	fectory, street, office bldg., etc.)	
2	21. certify that () (this hospital) attended the deceased fr	Marcal = 1050 . Vistor	7 10// 11 1/
	The second secon		.Z, 1966., that (
	saw the deceased alive on M.M. 19. Le.	that death occurred at the from the causes	allo oli ilia nale 219
	C C DI	ATTENDING MED. STAFF	~/-
	22c. PHYSICIAN'S	M.D. PHYS. DIRECTOR PHYS.	
	NAME (Type) E. Ambler Thompson, M.D.	49 Frederick Street, Ta	nartown MA
_			
23	e. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMET		
1	Burial July 28, 1966 Lutheran		Maryland
	PUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a, REC'D BY REGISTRAR 25b, RE	



MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. CDUNTY e. STATE COUNTY Carroll Nd. MARYLAND Carroll Pages b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Finksburg Finksburg .⊑ d. NAME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 4 Cedarhurst Road L Cedarhurst Road NO YES within etely carbon 3. NAME OF First DATE Month Day Middle DECEASED DF DEATH event, J. John Rhodes (Type or print) July 19 66 5. SEX 6. CDLOR OR RACE DATE DE BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED TO NEVER MARRIED remove last birthday) Months I Davs Hours in any o and Male White May 30, 1903 WIDDWED : 63 DIVORCED [1Da. USUAL OCCUPATION (Give kind of workdone | 10b. KIND DF BUSINESS OR 12. CITIZEN DF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
Barber death certificate be INDUSTRY New York **IISA** 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles S. Rhodes Eliza Miller 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITYNO. Address (Yes, no, or unkown) (If yes give war or dates of service) 218-18-1318 Mrs. Grace A. Rhodes Finksburg, Md. 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN requires that the ONSET AND DEATH ned by 1-transi PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage hrs n signed l burial-tran burial, cre DUE TO Hypertensive C.V. Disease Conditions, If any, which vears gave rise to immediate 유유 DUE TO cause (a), stating the underlying cause last. 88 CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY for use Health PERFORMED? certificate NO PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING []
DR CONTRIBUTING [] CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Pert I or Part II of Item 18.) hed f 2Dc. TIME DF INJURY Month, Day, Year (State) 20d. INJURY OCCURRED | 2De. PLACE DF INJURY (Home, farm, I 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. Not While While Not While at work 1966 to July 4 D July L . 19 66.. that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from... DIRECTOR: age 3 should ifed with the 19 66, and that death occurred at I.P.M, from the causes and on the date stated above. saw the deceased alive on July 4 22b. DATE SIGNED 22a. SIGNATURE ATTENDING E marton DIRECTOR 2 O HOSPITAL PHYSICIAN'S 22d. ADDRESS FUNERAL director, p NAME (Type) Martin E. Strobel. Main St. Reisterstown, Md. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23d. LOCATION (City, town or county) (State) 23c. NAME OF CEMETERY OR CREMATORY Finksburg, Md. Burial 166 Evergreen Memorial REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md. VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09759 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death. funeral s 1 and 2 ter death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY Washington Carroll o. COUNTY Maryland MARYLAND remave carbon papers Pages 1 n any event, within 72 hours after c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 (Rural) Sykesville 21722 Clear Spring 5国 12d e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS unknown filled Route #1 Springfield State Hospital and campletely fi remave carbon 3. NAME OF DECEASED (Type or print) Middle 4. DATE Month Doy Year Lost ROBINSON 19 66 DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH AGF (In years S SEX 6 COLOR OR RACE NEVER MARRIED 7 MARRIED 78 lost birthdoy) 7-2-87 Months Doys Hours white Male X DIVORCED WIDOWED gud 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 10c JSUAL OCCUPATION (Give kind of work done INDUSTRY 66 USA COUNTRY? during most of working life even fretired signed by the attending physician burial-transit permit Then are burial-transit permit Then are burial transition at remote the property of th Pa. 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME Nancy Carbaugh John Robinson burial, crematian, ar remo IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT Address (Yes, no or unknown) (If yes give war or dotes of service) 215-26-0812 Hospital Records 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART I DEATH WAS CAUSED BY Bronchopne INTERVAL BETWEEN 3 ONLL AND DEATH Bronchopneumonia DUE TO cardiovascular disease years Arteriosclerotic Conditions, if any, which gove rise to immediate couse (o), DUE TO storing the underlying couse Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(4)

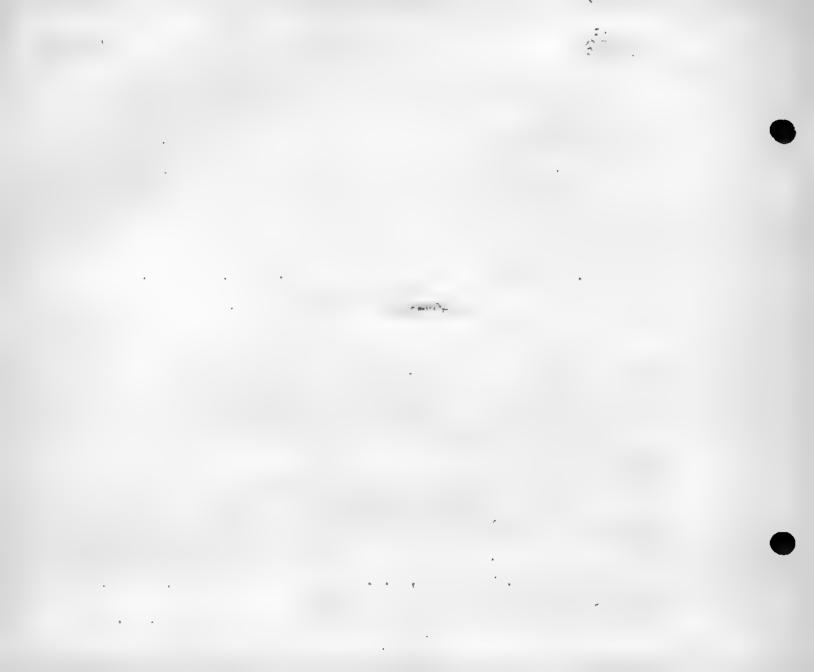
Chronic brain syndrome associated with cerebral arteriosclerosis WAS AUTOPSY PERFORMED? YES 🗌 NO 3 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Doy, Year factors street, office bldg., etc.) Hour o.m ot work 19 66 to 7-7-1-25 21. I certify that #) (this hospital) ottended the deceased from_ 1966, and that death accurred at 7:30aM, fram causes and on the date stoted above. saw the deceased alive an 226. DATE SIGNED 7-7-66 22o. SIGNATURE 40 DIRECTOR PHYS. M.D. Springfield State Hospital Wise III, M.D. 22c PHYSICIAN'S NAME (Type) 23d LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (Stote) 230. BURIAL, CREMATION, (County) 23b. DATE THEREOF NEAR LEARSPRING, WASH EMETERY 256 REGISTRAR S'SIGNATURE BY REGISTRAR 2So RECID 24 FUNERAL DIRECTOR ALBERT LI LEAF WILLIAMSPOXTA DATE

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 09766 PLACE OF DEATH 2, USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) · COUNTY ARROL o. STATE Filed b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporale limits, write c. CITY OR TOWN (H RURAL and give neagest town) Kesville 4 KesVII d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? OR INSTITUTION YES NO 2 NAME OF Middle 4. DATE Month Day Year DECEASED OF DEATH (Type or print) 1966 14 IF UNDER 1 YEAR IF UNDER 24 HRS 9 AGE (In years) 7. MARRIED A NEVER MARRIED B. DATE lost birthdoy) Months Days WIDOWED [DIVORCED [d USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (Slate or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 17. INFORMANT IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO Address {Yes, no jog unknown] INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b) and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gned gove rise to immediate DUE TO couse (a), stating the underlying couse lost. Marin PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO DE 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 206 ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) Month, Doy, Year 120d, INJURY OCCURRED (County) factory, street, office bldg., etc.) Hour a m. Not while While of work of work p. m. 7-22 1966, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from. 1966. and that death accurred at 9 AM, from the causes and on the date stated above saw the deceased alive on 22b, DATE 22o. SIGNATURE SIGNED ATTENDING STAFF PHYS DIRECTOR | PHYS M D. 22c. PHYSIC.AN'S 22d. ADDRESS 0 ā NAME (Type) FUNERAL 23a, BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town, or county) Stole) REMQVALI(Specify) 0 LINERAL DIRECTOR'S SIGNATURE 25a REC'D BY REGISTRAR REGISTRAR'S SIGNA 15M 9/59

ofter death.



20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09763 CERTIFICATE OF DEATH on and completely filled in by the funeroi ase remove corbon papers. Pages I and 2 ad in ony event, within 72 hours after leath. requires that the deoth certificate be executed within 24 hours after deoth 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY Carroll Maryland Washington MARYLAND b. CITY OR TOWN (If autside carparate limits, write RJRAL and a ve neorest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) 16 Yr. 1Mo. 16 ays Middletown, Md. Sykesville d STREET ADDRESS e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D.# 1 Springfield State Hospital YES I NO [3. NAME OF Middle Last 4 DATE Doy DECEASED Carrie Susan Springer (Type or print) DEATH IF UNDER TYEAR S SEX 6 COLOR OR RACE 7. MARRIED **NEVER MARRIED** 8. DATE OF BIRTH AGE (In years JE UNDER 24 HRS. last birthday) Manths Days 8-15-89 WIDOWED T Female White DIVORCED 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during mast af warking life, even if retired) COUNTRY? INDUSTRY signed by the ottending physic on burial-transit permit. Ther-phase burial, tremation, or removel, and i Washington Co. Md. U.S.A. Housework

13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME McAllister Fred Holmes Margaret 'S WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknown) ((If yes give war or dates af service) 16 SOCIAL SECURITY NO 17. INFORMANT Hospital Records 220-51-6618 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) ONSET AND DEATH PART I DEATH WAS CAUSED BY Pneumonia IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. **DUE TO** Conditions, if ony, which gove Cardian Failure rise to immediate couse (o), DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPS PERFORMED? YES 🗔 NO 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year factory, street, office blda., etc.) Haur a.m. Not While at work at work 21. I certify that (I) (this haspital) attended the deceased fram 5-30, 19,50, ta 7-17-, 19,66, that (I) (we) last saw the deceased alive an 7-17-, 19,66, and that death accurred at 4. M, fram causes and an the date stated above. , 19.50 , ta 7-17- , 19.66, that (I) (we) last 22a SIGNATURE 22b. DATE SIGNED DIRECTOR PHYS 22d ADDRESS 22c PHYSICIAN" NAME (Type) Frances Reid Nabors Springfield State Hospital 230. BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVM (Specify) Samples Manor Cemetery 7- 19- 66 Samples Manor, Md 2Sb REGISJRAR'S SIGNATURE 250. REC D' BY REGISTRAR 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09764 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH Carrol] Maryland Carroll The law requires that the death certificate be executed within 24 haurs after MARYLAND ages b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 Hampstead R.D.1 Westminster d. NAME OF HOSPITAL OR INSTITUTION (If not in haspito), give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Gill Ave. Carroll Co. Gen. Hospital YES | NO X NAME OF Middle remaye carban Last 4. DATE Month Day DECEASED NORMAN P. STEPHAN (Type or print) DEATH SEX 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR JE UNDER 24 HRS 7. MARRIED **NEVER MARRIED** last birthday) Hours 9/10/15 Male White WIDOWED DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10a USUAs OCCUPATION (Give kind of work done 11, BIRTHPLACE (County & State, or foreign country) during mast of working ute even a retired INDUSTRY ECHRIBAS Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Walter Stephan Mary Walsh 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give wor or dates at service) 17 INFORMANT 16. SOCIAL SECURITY NO. Address Mrs. Margaret Stephan, Hampstead, Md 19-11-2181 no 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c)) INTERVAL BETWEEN transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO burial Conditions, if any, which gave rise to immediate cause (o). DUE TO stating the underlying cause O FUNERAL DIRECTOM: After this certificate has been the 19. WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) PERFORMED? NO be retained by the hospital or 208 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Nat While ot work ot work 1960, ta 21. I certify that (I) (this hospital) attended the deceased fram the control of 25, 1966, that (1) (we) last saw the deceased alive on July 25, 19 64, and that death occurred at 9 25 M, from causes and an the date stoted above. 22a. SIGNATURE 22b DATE SIGNED 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town) 23o BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) Burial (Specify) 7/28/66 Manchester Immanuel Cemetery Md. 25b REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 1966 Tipton-Eline Hampstead. Md. DATE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 DEATH requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o COUNTY arrue b. COUNTY b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town Manchester mchuo d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 209 S. Main St. 207 S Main Street NO JA YES 1 3. NAME OF Middle 4. DATE DECEASED (Type or print) DEATH S SEX 6. COLOR OR RACE DATE OF BIRTH AGE IF UNDER 1 YEAR JNDER 24 HRS (n years 7 MARRIED **NEVER MARRIED** lost-bythdoy) 6/24**/**95 White Male WIDOWED DIVORCED 10o USUA, OCCL PATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life even if refired)
County Rds. Employee INDUSTRY COUNTRY Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME Ida Yingling Franklin Stephan 16 SOCIAL SECURITY NO. 17 INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 219-07-1941 Mrs. Melvie Stephan Manchester, Md. no 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the burial-transit burial, cremati DISET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions if any, which gove rise to immediate couse (a), DUE TO far use as the lifteealth prior to b stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been lost 19 WAS AUTOPSY PERFORMED? OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or fown) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc.) Not While 21. I certify that (1) (this hospital) attended the deceased fram 190, 10, 10, 10, 10, 190, that (1) (we) lost saw the deceased glive an 200428 1960, and that death accurred at 500 M, fram causes and on the date stated above. 92a, SIGNATURE 22b _DATE SEGNED ATTENDING director, page 3 should be filed v M.D PHYS DIRECTOR 22d ADDRESS Hampstead, Md. 22c, PHYSICIAN'S Porterfield M.C. NAME (Type) 23b. DATE THEREOF 23: NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) BURIAL, CREMATION, (County) 7/31/66 Leister's Cemetery Md. Westminster 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Tipton-Eline Hampstead, Md.

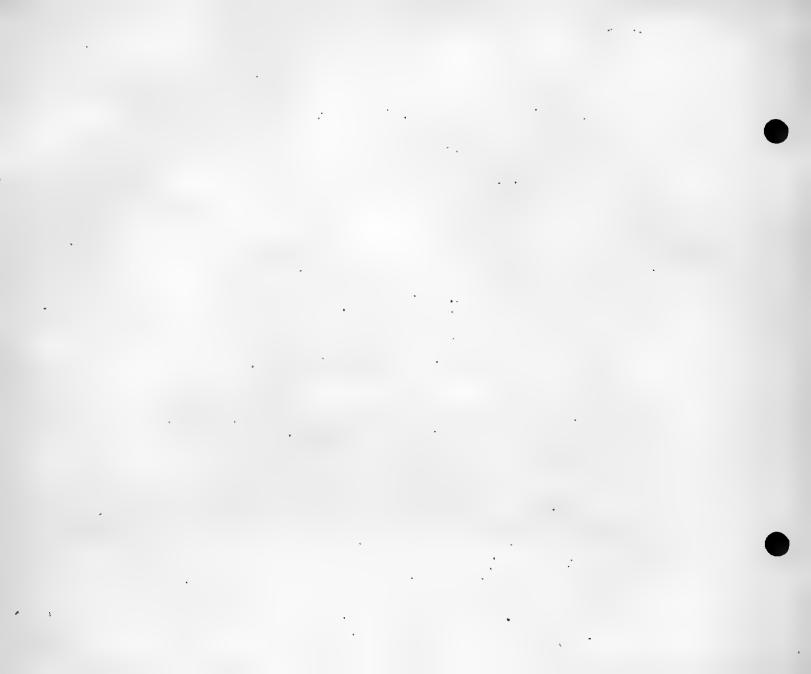


1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND		
로 끊이고	09766 CERTIFICATE OF DEATH	09765	
death.	1. PLACE OF DEATH a. COUNTY () 2 (2) 1) 2. USUAL RESIDENCE (Where deceased lived, if institution; Res a. STATE () 1. D. COUNTY () 2. STATE	idence before admission)	
fter the f	CARROLL MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND	RROll	
Irs a Page Ours a	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sukesville Sukesville	un Bise uestezi (omu)	
hou ed in ers.	d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	0. IS RESIDENCE ON A FARM?	
n 24 n 24 pap pap	Office of Dr. Okutman OAKlAND Rd.	YES NO	
executed within 24 hours after death and completely filled in by the formeral remove darbon papers. Pages 1 and 2 any event, within 72 hours after death.	3. NAME OF DECEASED (Type or print) Ethe First Middle TROTT Last 9. DATE DEATH JULY 2:	Day Year	
Com Com	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1	YEAR IF UNDER 24 HRS.	
and and and any	Peimale (Dhite WIDOWED OIVORCED 1/1/Au 16, 1920 146 yrs.	Days Hours Min.	
	102. USUAL OCCUPATION (Give kind of work done of working life, even if retired) 105. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fereign country) 12. CIT (COUNTRY) 12. CIT (COUNTRY)	IZEN OF WHAT	
death certificate be ne attending physiciar permit. Then please tion, or removal, and i	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME,	31/7	
ertifical ing I	John CARVER Nellie HillMAN		
ttend mit.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service)	1001:11 M	
dea he a peri	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN	
law requires that the trending physician. has been signed by the set the burial-transit prior to burial, cremain	PART I. DEATH WAS CAUSED BY: Coronary Ocelusion	INTERVAL BETWEEN ONSET AND DEATH	
thay ysicii gned ial-tr	tout DUE TO DIE O 10	1	
phres g phres en si bur	Conditions, If any, which gave rise to Immediate DUE TO	2 yes	
v req andin s be s the	underlying cause last. (c) # Experio Selection, Hyperthonorm	6-1900	
The favor attracted or attracted to the favor attracted to the favor and the favor attracted to the favor attracte	PARTILIOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Contribution	19. WAS AUTOPSY PERFORMED?	
N: The tal or iffical for the tal	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Pert of Item 18.)	YES NO P	
PHYSICIAN: the hospital this certifi detached fo detached fo			
PHYS the I this detad	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (Coun factory, street, office bldg., etc.) P.m. 19 At work at work	ty) (State)	
JNG I by After I be Stat		Z 11 1 10 1 10 1 10 1	
OR ATTENDING be retained by JIRECTOR: After ge 3 should be	21. I certify that (I) (this hospital) attended the deceased from 2 1962, to 1 1172, 1964 saw the deceased alive on 1 1172, and that death occurred at 2 M, from the causes and on the	that (I) (we) last added above.	
R AT RECT 3 SI	22a. SIGNATURE () (22b. DA)	TE SIGNED	
AL OR nay be page filed it filed it	22c. PHYSICIAN'S ATTENDING D MED. STAFF TO PHYS. 22c. PHYSICIAN'S 22d. ADDRESS (1)	25.06	
O HOSPITAL OR ATTENDING PHYSICIAN. The taw requires that the Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR. After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, cre	NAME (Type) Sani Okutman Sykesville,	Md.	
TO ROSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifical Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicitor, page 3 should be detached for use as the burial-transit permit. Then I should be filed with the State Dept. of Health prior to burial, cremation, or removal.	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or country) 7-26-66 NCU OAKIANI	nty) (State)	
-	24. FUNERAL DIRECTOR ADORESS AD 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S		
VR AI5 (4) 20M 1/65	Horry W. Haight Sykesville Hid DATEJUL 26 1966 Juliane	es judge	
20111 1/100			



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH and 2 24 hours after death, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Carroll Haryland Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENCTH OF STAY IN 1b and completely filled in by emove carbon papers. Pag any event, within 72 hours write RURAL and give nearest town) 4 mo. 13 d. Rural - Sykesville Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 1500 Virginia Avenue NO ST 3. NAME OF Middie Last 4. DATE Month Year DECEASED (Type or print) Twigg DEATH 1966 Sarah Levy July 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH ACE (In years I IF UNDER I YEAR IF UNDER 24 HRS last birthday) | Months | Days WIDOWED A DIVORCED [11-10-1889 White 76 emale 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT cian ase I nd in death certificate be New York, New York U.S.A. Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harris Levv Bessie Simon 15. WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) I (If yes hire war or dates of service) Springfield Hospital, Sykesville. None 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Cardiac failure IMMEDIATE CAUSE (a). been signer the burial-transfer to burial, DUE TO Cerebral Vascular Accident. Conditions, If any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CBS associated with circulatory disturbance other than cerebral arter oscience, with psychotic reaction.

205. ACCIDENT WAS UNDERLYING [] | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18 OR CONTRIBUTING [] CAUSE OF DEATH (I FEITHER, NOTHER MEDICAL EXAMINER) PERFORMED? NO T YES [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While p.m. at work at work v 21. I certify that (IX(this hospital) attended the deceased from February 18 1966, to July 1, 1966, that tilk(we) last _1966 , and that death occurred at3 - 30MI from the causes and on the date stated above. 22b. DATE SICNED 228. SICNATURE ATTENDING PHYS. page DIRECTOR L PHYS. FUNERAL PHYSICIAN'S 22d. ADDRESS director, p should be 1 Springfield State Hospital Buyukunsal, 23d. LOCATION (City, town or county) BURIAL, CREMATION, 1 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) 23a. REMOVAL (Soecify) Allegany, Cumberland. East View Cemetery 24. FUNERAL DIRECTOR ADDRESS REC'D BY RECISTRAR | 25b. REGISTRAR'S SICNATURE Cumberland. Hafer 230 Ralton Ave John who VR A15 (4) DATE 20M 1/65



RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH CERTIFICATE funeral should PLACE OF DEATH 2. USUAL RESIDENCE (Where deceesed lived, if institution: Residence before admission) a county Carroll Maryland b. COUNTY Frederick MARYLAND 높 다 년 b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Middle burg nearest town) Lantz O d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Brookfield Manor Nursing Home YES NO K 3. NAME OF DATE Month DECEASED (Type or print) MARY WAYNANT \mathtt{Julv} DEATH 19 66 6. COLOR OR RACE 7, MARRIED NEVER MARRIED A 1 8. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS. IF UNDER I YEAR 66 birthday) and Months Feb. Female WIDOWED [DIVORCED [10a. USUAL OCCUPATION [Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Own Home Pennsylvania USA Housewife 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME please attending Marion J. Bender Amaricus E. Waynant 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unkown) (If yes give were redesof service) Sabillasville, Md. Vaughn Waynant None 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c),) INTERVAL BETWEEN ONSET, AND DEATH PART I. DEATH WAS CAUSED BY: inebro visules acciden 2 days IMMEDIATE CAUSE (e) Cerebral atheresclerosis: DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), stelling the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? Cardio Vanisa disease NO D 20e, ACCIDENT WAS UNDERLYING [] 1 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Pert II of item 18] OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stelle) 20c. TIME OF INJURY Month, Dey, Yeer fectory, street, office blda., etc.) While Not While Hour a.m. el work al work 31.64..., 19....., that (1) (we) last 21. I certify that (I) (this hospital) affended the deceased from 4/4. ,, to... 19.. ..., and that death occurred at AMM, from the causes and on the date stated above. saw the deceased alive on... 22b. DATE SIGNED DIRECTOR PHYS. AA D 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Union Bridge. Maryland Caricofe 23d. LOCATION (City, town or county) 23a, BURIAL, CREMATION, 23b, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify)
Burial Thurmont Fred. Co. Md. 8-3-66 Blue Ridge Cemetery 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE Barmond E. AUSSE ager VR A15 (4) Thurmont, Md. DATE 15M 7-62



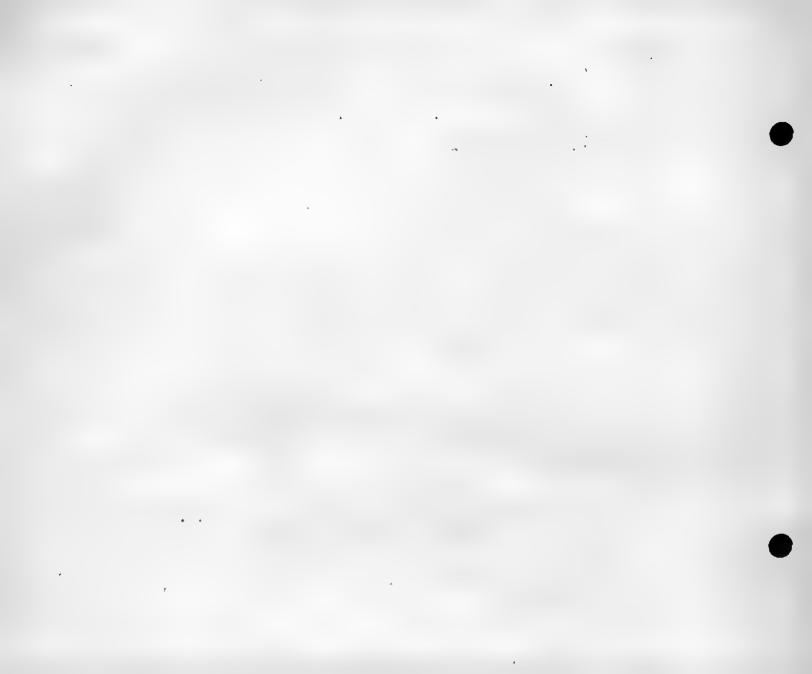
OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE DEATH 1. PLACE OF DEATH USUAL RESIDENCE (Whate deceased lived, If institution; Residence before admission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN IIf owiside corporete limits, write RURAL end gave nearest town! write RURAL and give nearest town! d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address a. IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO IZ 3. NAME OF Middle 4. DATE Day DECEASED OF (Type or print) DEATH AGE (In years IF UNDER 1 YEAR 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED lest birthday) Months Deys 10a. USUAL OCCUPATION (Give kind of work 1Db KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY dons during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 16. SOCIAL SECURITY NO. 1 17. INFORMAN (Yas, no, or unkown) | (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), end (c), ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which ſЫ gave rise lo immediate causa DUE TO (a), staling the undarlying causa lest. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO P 20s. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURED. [Enter neture of neury in Part I or Pert II of them 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, ferm, (County) (Steta) 20c. TIME OF INJURY Month, Day, Yeer 2Df. (City or town) lactory, street, office bldg., etc.) Not While While Hour a.m. at work at work p.m. 21. I certify that (I) (this hospital) attended, the deceased from.... 10./. and that death occurred at // M, from the causes and on the date stated above. saw the deceased alive on "SIGNATURE 22b. DATE ATTENDING PHYS DIRECTOR M.D. 27d. ADDRESS 22c. PHYSICIAN'S 23d. LOCATION (City, town or county) (Stata) 23a. BURIAL, CREMATION, | 23b REMOVAL (Specify) Brooklyn MacPelah Cemetery 25e REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS. 24 FUNERAL DIRECTOR'S SIGNATURE VR A1S (4) Tipton-Eline Hampstead, Md. 15M 7-62



41	Divisio		MARYLAND STATE DEF RCH AND RECORDS, 301			ND 21201
	09770		CERTIFICATE	OF DEATH		09769
3	PLACE OF DEATH a. COUNTY CARROLL		MARYLAND	2. USUAL RESIDENCE (Wh o. STATE	ere deceased lived, if institution b COUNT	
	b. CITY OR TOWN (If autside write RURAL and give ne lestminis	carporate limits, arest lawn)	2 VIS.		de carporate limits, write RURA	
	d NAME OF HOSP TAL OR IN	STITUTION (If not in haspite) g		d STREET ADDRESS	ain St.	e IS RESIDENCE ON A FARM? YES NO
3	NAME OF DECEASED	First	Middle	Last	4. DATE Manth OF	Day Year
S	(Type or print) SEX 6 COLO	Gladys DR OR RACE 7 MARRIED	<u> </u>	Whelah DATE OF BIRTH	9 AGE (In years last birthday)	TO 19 66 MF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
11 d	Ti Do. USUAL OCCUPATION (Give kn uring most of working life, even	MIDOWED 10b K! if retired)	DIVORCED DIVORCED DIVORCED DIVORCED DIVORCED DIVORCED DIVORCED	Tune 7 19	02 64 yrs. State or fareign country)	12 C TIZEN OF WHAT COUNTRY?
7	3 FATHER S NAME	,		Ilaryland Mother's Maiden Na		L USA
1	Martin Hu S WAS DECEASED EVER IN U.S Yes, no, or unknown) (If yes gi	ARMED FORCES? 16 ve war or dotes af service)	50CIAL SECURITY NO 77 II	Beasi WFORMANT Thomas II	. helan Address	mons
F	PART I DEATH WAS	ter anly one cause per line for			farction	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which size to immediate cause stating the underlying colors.	DUE TO (b)	theroscle			?
TION	PART II. OTHER SIGNIFICAN	T CONDITIONS CONTRIBUTING	O DEATH BUT NOT RELATED TO T			19. WAS AUTOPSY PERFORMED? YES NO
COST DICATION		YING (1) 205. DE	SCRIBE HOW INJURY OCCURRED	finter nature of injury in Po		
1000000	20c. TIME OF INJURY Mor Hour o.m. p.m.	nth, Doy, Year 20d II White 19 at wor	Not While facto	E OF INJURY (Home, form, ary, street affice bldg., etc.)	20f (City or tawn)	(County) (Stote)
	saw the decease	t (I) (this hospital) atten d alive an Neve	ded the deceosed from 19, and that	, 19 death accurred at 2	M, from causes a	, 19 <u>46,</u> that (I) (we) la and an the date stated above
	22c. PHYSICIAN'S	om R C	Rouse M.C	ATTENDING D	IED. STAFF PHYS.	22b DATE SIGNED
	NAME (Type)		Rourke, H.	D		
	30. BURIAL, CREMATION, REMOVAL (Specify) LULI	23b. DATE THEREOF 7-22-66	23c NAME OF CEMETERY OR C	£k.	23d LOCATION (City or Tow Lalto.,	IId.
	24. FUNERA, DIRECTOR	1-41016	ADDRESS	PATE PETE	BY REGISTRAR 1955 25b. REG	istrar's signature

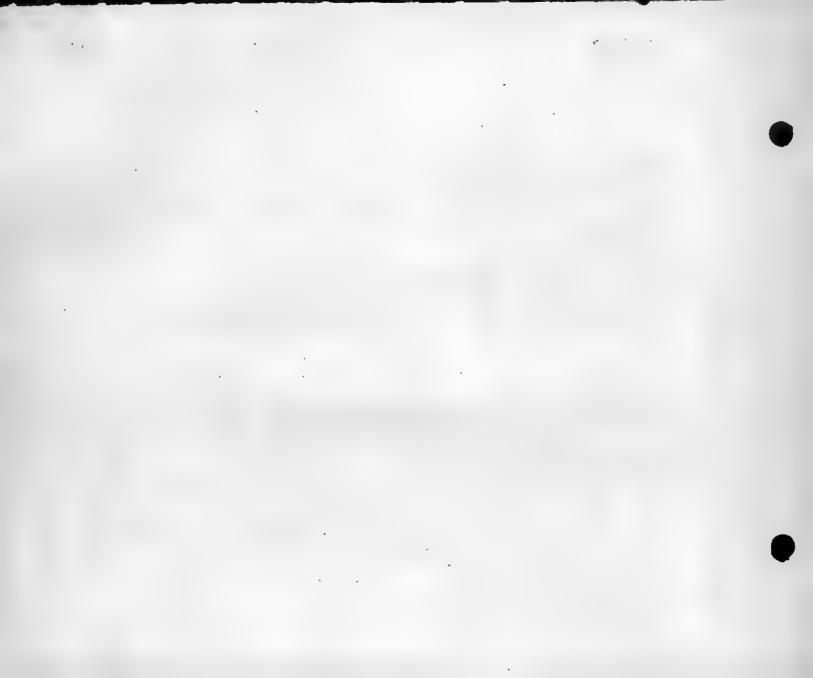


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death by the funeral Pages 1 and 2 emave carban papers. Pages 1 and 2 any event, within 72 haurs after depth 2. USUAL RESIDENCE (Where deceosed lived if institution Residence PLACE OF DEATH o. COUNTY **b** COUNTY Maryland Carroll Carroll MARYLAND b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Rural -- Sykesville Woodbine 11m. 22d d STREET ADDRESS e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1 Springfield State Hospital NO TI NAME OF Middle 4 DATE OF First Lost Month Year and campletely f remave carban DECEASED 19 66 Maudie Belle White DEATH Type or print) IF UNDER 1 YEAR AGE (In years IF UNDER 24 HRS. DATE OF BIRTH S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED burthdoy) Months Hours 3/17/87 female white [30] WIDOWED DIVORCED 11 BIRTHPLACE (County & State or foreign country) 12, CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR the attending physician a sit permit Then stease nation, or remavill and y COUNTRY? during most of working life even if retired) INDUSTRY USA Virginia 14. MOTHER'S MAIDEN NAME 13. FATHER 5 NAME Luella Rogers crematian, or remay Thomas Sargent 17 INFORMANT 16 SOCIAL SECURITY NO IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 216-10-1224 Springfield Hospital records, Sykesville INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Congestive heart failure IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO burial, Conditions, if any, which gove (b) rise to immediate cause (a). DUE TO as the prior tak stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction. 3 should be detached far use with the State Dept. of Health p NO A 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (County) (Stote) 20e PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED foctory, street, office bldg., etc) Hour a.m. Not While at wark at work e deceased from $\frac{7/13}{}$, 19.64, to $\frac{7}{5}$, 19.66, that m (we) last $\frac{19.66}{}$, and that death occurred of $\frac{6.30}{}$ M, from causes and an the date stated obove. 19.64 1956 . that the (we) last 21. I certify that (3) (this haspital) attended the deceased from_ 3 shauld saw the deceased alive on 220 SIGNATURE 22b DATE SIGNED STAFF PHYS. **ATTENDING** MED. DIRECTOR X M.D. director, page 3 shauld be filed v PHYS State Hospital Springfield 22d. ADDRESS 22c. PHYSICIAN'S Moises Sucholeiki, M.D. NAME (Type) Sykesville, Maryland 23d. LQCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF (Stote) BURIAL CREMATION, PEMOVAL (Specify) /) 2567 REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR **ADDRESS** FUNERAL DIRECTOR VR A15 (4) Menilo 1946



1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
- 2-		0.0 m m a	E OF DEATH	09771
thin 24 haurs after death. y filled in by the funeral on papers. Pages 1 and 2 within 72 haurs after death.	1	PLACE OF DEATH O. COUNTY PROLL MARYLAND CITY OR TOWN (If auriside corporate limits, write RURAL and give nearest town) AND TERM MARYLAND C LENGTH OF STAY IN 16 25 YRS MAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) CARROLL C TRAL HOSPITAL	o. STATE OCCUPY OR TOWN (If aurside OCCUPY OR TOWN (If aurside) OCCUPY OF TOWN (If aurside)	corporate limits, write RURAL and give nearest town) NSTER RT # 4 e IS RESIDENCE ON A FARM?
executed wi	S	NAME OF DECEASED (Type or print) SEX 6 COLOR OR RACE WIDOWED DIVORCED USUAL OCCUPATION (Give kind of work done in most of working He, even if retired) FATHER'S NAME NAME FATHER'S NAME	Last 4. NIKE 8. DATE OF BIRTH PRIL 27, 19, 11 BIRTHPLACE (County & Sto	te or foreign country) 12. CITIZEN OF WHAT
quires that the death certificate be physician. signed by the attending physician ar burial-transit permit. Then please r burial, crematian, ar removal, and in	15	WAS DECEASED EVER IN U.S. ARMED FORCES? s, na, ar unknown) (If yes give war ar dates af service) 2.19 - 0/-1765 M 18 CAUSE OF DEATH (Enter apry ane cause per line far (a), (b), and (c)) PART. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a)	14. MOTHER'S MAIDEN NAME MARY EL INFORMANT RS FRANCIS E.A. Throwboeis	LEN CARR Address
4: The law requires that the artending physician. The has been signed by the use as the burial-transit ralth priar to burial, cremated the prior to burial, cremated.	ATION	Conditions, if ony, which gove rise to immediate couse (o), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO) THE TERMINAL DISEASE CONDITION	ON GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES NO
OR ATTENDING PHYSICIAN: be retained by the hospital a DIRECTOR: After this certificat je 3 should be detached for ed with the State Dept. af Hec	MEDICAL CERTIFICATION	Hour a.m., 19 While Not While of wark I fo	LACE OF INJURY (Home, form, actory, street, office bldg , etc.)	20f. (City or town) (County) (State)
		220. SIGNATURE	M.D ATTENDING MED DIRE 22d. ADDRESS	to 7/21/66, 19_, that (1) (we) last M, fram causes and an the date stated above. CTOR STAFF 22b. DATE SIGNED T/4/66 Lt. Westminster, and
TO HOSPITAL Page 4 may To Hospital Page 4 may To Hospital Page 6 may A m		BURIAL CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OF SURVINE TO 1/25/66 LEISTER'S ADDRESS ADDRESS LE TUMBLE LE L'ALLE L'A	CEMETERY	23d. LOCATION (City or Town) (County) (Stote) RURAL, NESTMANSTER MD REGISTRAR 1966. REGISTRAS SIGNAPLE JUSTICE.

1 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
FOR STATE	OTTO	FICATE OF DEATH 00プラン		
HEALTH DEPT.	View of the second seco	AL RESIDENCE (Where deceased lived, If institution: Residence before admission)		
18 A	OUNTY CARRYLAND BASYLAND BASYLAND			
Cessary, the funeral se 5 may be Department after death.		OB TOWN (If outside corporate limits, write RURAL and give nearest town)		
S m S m		T ADDRESS 0. IS RESIDENCE		
delay loctostary of the funeral Page 5 may b State Department hours after death	32	on. man of DN A FARM?		
M3.	E OF First Research Wilhe	St A. DATE Month Day Year OF DEATH TURN 3/ 1966		
Fig. 17.	(1) HEYER MARKIED 1//2	F BIRTH 9. AGE (in years If UNDER I YEAR IF UNDER 24 HRS 12 74 9. AGE (in years If UNDER 1 YEAR IF UNDER 24 HRS 12 74 10 10 10 10 10 10 10 1		
er death.	AL OCCUPATION (Give kind of work done 10b. Kind of Business or 11. Bir ingst of working life, even if retired)	YTR. 12. CITIZEN OF WHAT COUNTRY?		
	Laborer	aryLand Usa		
ours aft. m 18, G e alone pages in any	Peter Wilhelm	Tier's Maiden Name Tier the Hate		
24 ho in Item Office File I, and	DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN or unknown) (17 yes give war or dates of service)			
within 2 pencil in miner's o permit. I removal,	Co 1 220-16-1734 Miro	, L'ergel Wilhelm Hampetead, la		
uted with in penci	CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	Interval Between ONSET AND DEATH		
_ 2 po of G	4201 OUE TO (1AA 1M A 24 RD T)	erki Schrois (mpm)		
ld be exe "pendin f Medica burial-tr crematio	b rise to immediate be (a), steting the DUE TO	7101 - 401-01		
370 % _	erlying ceuse last, (c)	ETERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUIDPSY		
R. This certificate sho rate, writing the wor. forwarded to the Chi 3 should be used as agent, prior to burial	THE OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	PERFORMED?		
	. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Entended of the contributing) is of death.	ter nature of injury in Part I or Part II of Item 18.)		
	Hour a.m. 19 at work at work	JRY (Home, farm, 201. (City or town) (County) (State)		
MINEI d be Page		The state of the s		
the certificates the certificates the certificates of the certific	1. I certify that I took charge of the remains described above, held an Autoeath resulted from: Natural causes Accident . Suicide	psy, Inspection, Inquiry, and In my opinion . Homicide Undetermined manner		
EDICAL EXA		IEF MEDICAL EXAMINER		
= 0 . 5 2 9	nature 7 30 100 100 100 100 100 100 100 100 100	SISTANT MEDICAL EXAMINER 22. DATE SIGNED		
DEPUTY MED tease executivector. Page stained for your Funeral DIF	MINER'S	PUTY MEDICAL EXAMINER Horses (Street, city, town, or county)		
	JRIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMI	ATORY 23d. LDCATION (City, town or county) (State)		
5 2 5 0	REAL DIRECTOR / ADDRESS	258. REC'D BY REGISTRAR 250. REGISTRAR'S SIGNATURE		
VR AISME (5)	ston-ELiNe HampsTead, Md	DATE AUG 3 1966 floorly Juige		
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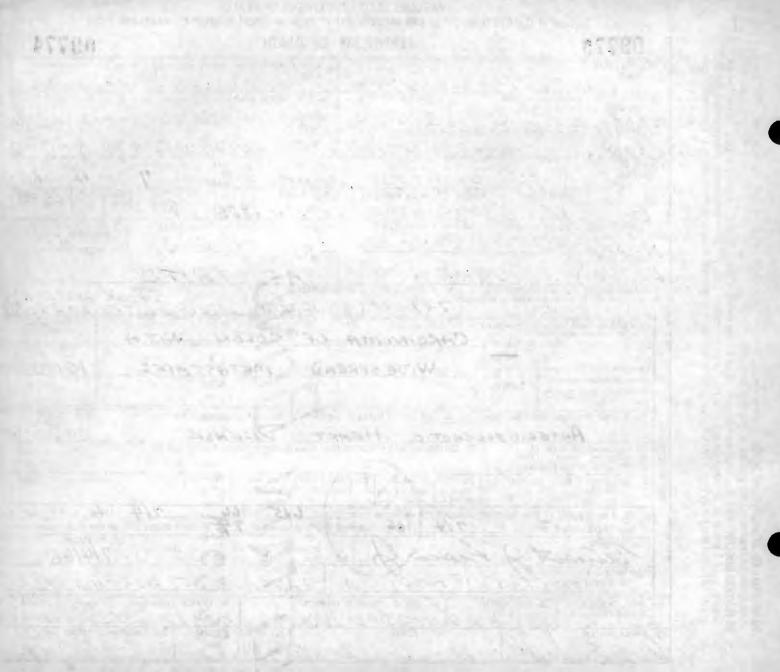


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT-1. PLACE OF DEATH IISUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY Maryland b. GOUNTY Carroll Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) funer may b Rural - Millers Westminster
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS ay ... 3 to ... State hours YES X NO County General Hospital 3. NAME OF First DATE Month Middle Last Day DECEASEO 2음 19 66 YELTON 14 REBECCA (Type or print) DEATH 5. SEX 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS E lest birthday) | Months | death. | Pages Davs Hours White 27/90 Female WIDOWED . DIVORCED [10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR during most of working life, even if retired) iNDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT **COUNTRY?** USA North Carolina Hwf. along 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Amanda Jane Street Charles R. Yelton File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) Mr. Henry Yelton Millers. Md. 213-16-1037 EXAMINER: This certificate should be executed within certificate, miting the word "pending" in pencil is " in pencil Examiner's no 18. CAUSE OF OEATH [Enter only one cause, per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH DEATH WAS CAUSED BY: burial-transit 5 IMMEDIATE CAUSE (e) cremation, **DUE TO** Conditions, If any, which (b) gave rise to immediate DUE TO cause (e), steting the co ed as a burial, underlying cause last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT TION GIVEN IN PART 1(e) 19. PERFORMED? use to b No 208. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 3 5 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part) or Part 1 of Item 48. etured H2 should ent, pri 3 shou agent, MEDICAL (County) (State) 20c. TIME OF INJURY, Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) While at work at work the certi 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X. Inquiry and In my opinion FUNERAL DIRECTOR: Health or its design Undetermined manner Natural causes Accident \ Suicide Homicide death resulted from: CHIEF MEDICAL EXAMINER YOUT 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATUR for DEPUTY MEDICAL EXAMINER **EXAMINER'S** director. retained Adoless Great City town In county Hillers NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State 0 Md. **′17/**66 Burial Kirkridge Cometery REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 106 VR ALSME (5)Q Tipton-Eline Hamstead. Md. 1/65



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09775 requires that the death certificate be executed within 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) and completely filled in by the funera remove carbon papers. Pages than o. COUNTY b. COUNTY b. CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) ESTMINSTE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within YES NO A 3. NAME OF 4 DATE Month Year DECEASED (Type or print) OF DEATH 1966 9. AGE (In years lost birthday) S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dovs Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY 005EW11=6 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova WAS DECEASED EVER IN U.S. ARMED FORCES 17 INFORMANT 2 4 MANCHESTERAVE WESTHINSTER, MD (Yes, no, or unknown) (If we give war or dates of service) 217-09-0703 MR. HERSCH 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) INTERVAL BETWEEN buriol-tronsit PART I, DEATH WAS CAUSED BY: ONSET AND DEATH WITH CARCINOMA COLON IMMEDIATE CAUSE (o) signed by DUE-TO WIDE SPREAD 10mo. Conditions, if ony, which gove METHSTHSES rise to immediate cause (a). **DUE TO** stoting the underlying couse as the the hospitol or ottending this certificate has been lost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? for use YES NO G HRTERIO SCLEROTIC 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port | or Port || of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING FI CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour o.m. foctory, street, office bldg., etc.) TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram 1966 to 19<u>62</u>, that (I) {we} last 1966, and that death accurred at 7 5 M, fram causes and an the date stated above saw the deceased alive an 220. SIGNATORI 22b. DATE SIGNED **ATTENDING** DIRECTOR M.D. 22d. ADDRESS 224 PHYSICIAN'S -10000 NAME (Type) ANCHOR director, 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City of Town) (County) REMOVAL (Specify) PUNERAL DIRECTOR 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (40 20 M 1/66 DATE JU mes C

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09776 CERTIFICATE OF DEATH by the funeral s. Pages I and 2 haurs after degal 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Maryland Carroll Frederick MARYLAND b, CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town ural) Sykesville Frederick 20d (rural) e. IS RESIDENCE ON A FARM? by the ottending physician and completely filled in transit permit. Then please remove carbon papers. cremotion, or removol, and in any event, within 72 h d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital 207 W. 7th. Street YES NO SE The low requires that the death certificate be executed within 3. NAME OF First Middle DATE Lost Month Doy Year DECEASED OF 19 66 Grafton Zimmerman Bernard (Type or print) DEATH IF UNDER 24 HRS. AGE (In years IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthdoy) Months Hours Doys 1-1-65-1895 white WIDOWED DIVORCED male 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Truck driver INDUSTRY COUNTRY? Maryland 13. EATHER'S NAME Loward J George Zimmerman 14. MOTHER'S MAIDEN NAME Amanda Staley ottending p 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yes, no, or unknown) (If yes give wor or dotes of service) HANDER HERE Hospital Records 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p burial, cremotic ONSET AND DEATH Acute pulmonary embolism IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. **D FUNERAL DIRECTOR:** After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, cre DUE TO Infected gangrenous decubitus ulcers Weeks Months Conditions, if any, which gove (b) rise to immediate couse (o), DUE TO stoting the underlying couse Days Bronchopneumonia last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) OF YES X NO uncertain cause. Huntington's Chorea, with psychotic reaction
20c. ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item IB.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Not While foctory, street, office bldg., etc.) Hour o.m. ot work 19 65 that ((we) last 19 60 to 5-15 21. I certify that (4) (this haspital) attended the deceased fram. 19 66, and that death accurred at 4:30M, fram causes and an the date stated above. saw the deceased plive an 7-5-22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. 7-6-66 DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S A. Arengo, M.D. Springfield State Hospital NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b. DATE THEREOF (County) 23o. BURIAL, CREMATION, BUR LAPOCITY) Frederick, Md. 21701 Mt. Olivet Cemetery July 9-1966 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Elivoo Milanter VR A15 (4) 20 M 1/66 Frederick, Md.21701 M.R. Etchison & Son DATE

